Your Hospital's Logo Here

VOLUNTEER SERVICE PHYSICIAN RELEASE FORM

VOLUNTEER SERVICES
Street Address
City, State Zip
Tel (202) 555 - 1212

I have examined ____, and to my knowledge, he / she is free from infectious diseases, with no contra-indication against his / her physicial and emotional ability to perform volunteer services at this Hospital.

PPD MUST HAVE BEEN RECEIVED WITHIN THE PAST 3 MONTHS			
PPD (mantoux):	DATE PLANTED:	DATE READ:	RESULT (mm induration):

CHEST X-RAY FOR PERSONS WITH A HISTORY OF POSITIVE PPD WITHIN PAST 12 MONTHS	
CHEST X-RAY RESULT:	DATE:

TB SYMPTOM SURVEY	
TB SURVEY RESULT:	DATE:

PHYSICIAN SIGNATURE & OFFICE INFORMATION	
PHYSICIAN'S SIGNATURE:	DATE:
PHYSICIAN'S NAME (Print):	TELEPHONE:
PHYSICIAN'S ADDRESS: (Street) (City) (State) (Zip)	