WellStar West Georgia Medical Center
Volunteer Medical Release Form

Please have your primary care physician complete this form. This document is strictly confidential.

Please print.

Volunteer Applicant's Name **Applicant's Phone Number**

is applying to volunteer at WellStar West Georgia Medical Center.

Do you know of any physical, emotional, or mental limitations that would interfere with the applicant's ability to function in a hospital atmosphere? Yes ____ No ____

If yes, please elaborate: ____

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If the applicant is born after 1957, are DPT, MMR and Chicken Pox immunizations up-to-date?

PLEASE ATTACH PROOF (Record or Titer Test) Yes ____ No ____

Additional Comments: ____

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Printed Physician Name

______________________________________ ____________________
Physician's Signature Date

____
Office Address

____
Office Phone Number

WellStar West Georgia Medical Center
Department of Volunteer Services
1514 Vernon Road, Lagrange, GA 30240
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