# VOLUNTEER RESOURCES

## MEDICAL CLEARANCE FORM UNDER 18

**Volunteer, please complete the information below:**

Date: _____

Volunteer Name: _____ Gender: _____

Date of Birth: _____ SSN: _____

Address: _____

Home Phone: _____Other Phone: _____

I understand the medical tests on the following page are required by the New York State Health Code as a prerequisite to my beginning volunteer service at the hospital. I agree to undergo the following tests to obtain medical clearance.

Volunteer Signature: _____

Parent/Guardian Signature: _____

**Please do not submit unless all below items are complete:**

- ❒ The lot numbers are filled in for your tuberculosis skin test(s)
- ❒ Tuberculosis skin test(s) dates received and read are filled in
- ❒ Copy of MMR record is attached

To submit these forms you can fax it or drop it off in person to:

New York Methodist Hospital, Employee Health Services
501 Sixth Street, Room 8B

Fax: 718-246-8571
Phone: 718-246-8570

**To Be Completed by NYM's Department of Employee Health Services**

Health Service Appointment: ____ Cleared _____ Not Cleared

Practitioner's Signature: _____ Date: _____

**Please check if volunteer had CXR:** ☐

**VOLUNTEER NAME: _____**

**MEDICAL FORM FOR VOLUNTEERS: UNDER AGE 18**

Please have the following information completed and signed by your doctor or practitioner

1. **TUBERCULOSIS SCREENING: (must be current within past year )**

We require either:

☐ TST: Date planted:_____ Lot:_____ Location:_____ Administered by:_____

Date read:_____ Results: + / - _____mm induration Read By:_____

**--OR--**

☐ QuantiFERON—TB Gold Blood test

Date Administered: _____ Results: +/- _____

**N.B.: If TB test results are positive, please attach copy of most recent chest x-ray report.**
Date of Chest x-ray:_____ Results:_____

2. **VACCINATION SCREENING**:

☐ Please attach a copy of MMR

3. **DISABILITIES:**

To the best of your knowledge, does this applicant have any physical or emotional disabilities we should consider prior to placement? _____Yes_____No

If Yes, please explain _____

4. **SIGNATURE:**

In compliance with the New York State Health Code, I have examined the applicant and have found him/her to be free of any health impairments that would pose a potential risk to patients and hospital personnel or which might interfere with his/her duties.

_____ _____ _____
**Practitioner's Name & License No** **Date** **Practitioner's Signature**

**The following test will be provided by New York Methodist Hospital on your first day of service :**

1. ☐ Urine toxicology_____

Please return this form to (physical location not mailing address)

**New York Methodist Hospital, Employee Health/ 501 Sixth Street, Suite 8B**
**Brooklyn, New York 11215**
**TEL: (718) 246-8570 FAX: (718) 246-8571**