

ST. LUKE'S-ROOSEVELT HOSPITAL CENTER
Volunteer Department Medical Form for Crime Victims Treatment Center

Name of Applicant: _____ Date of Birth: _____

Physician: _____ Physician's Phone No.: _____

Physician's Address: _____
(No. & Street) (City) (State & Zip Code)

Dear Physician:

The above applicant has applied to provide volunteer services as an CVTC Advocate at the St. Luke's-Roosevelt Hospital Center. The work will involve patient contact in the Emergency Department.

IN COMPLIANCE WITH THE NEW YORK STATE HEALTH CODE, VOLUNTEERS MUST HAVE A RECORDED MEDICAL HISTORY AND PHYSICAL EXAMINATION PRIOR TO WORKING. WE WOULD APPRECIATE IT IF YOU WOULD FILL OUT THE FOLLOWING QUESTIONNAIRE:

1. How long have you known the applicant? _____
2. Does the applicant have any health impairment which might represent:
 - a) A potential risk to self, patients or hospital personnel? Yes No If Yes, explain:

 - b) Interfere with the performance of his/her duties? Yes No If Yes, explain:
3. Is the applicant habituated or addicted to non-prescription drugs, or alcohol, or any other substance, which may alter the individual's behavior? Yes No If Yes, Explain:
4. Has the applicant had a complete medical and physical examination? Yes No

Please record the date of last physical examination: _____

TUBERCULOSIS: *New York State Health Code requires tuberculin testing on new volunteers*

_____ Date of PPD (must be within the last year) Negative PPD Positive PPD

If PPD is Positive, the results of a chest X-ray done within the past three months is required

_____ Date of Chest X-ray Result: Negative Positive

RUBELLA (German Measles)

One dose of vaccine _____ Date of Vaccination

or Immunity demonstrated by titer _____ Date of Titer Test _____ Titer Reading

*RUBEOLA (Measles)**

Two doses of vaccine _____ Date of 1st Vaccination
_____ Date of 2nd Vaccination

or Immunity demonstrated by titer _____ Date of Titer Test _____ Titer Reading

or Had disease, confirmed by office records _____ Date of Disease _____ Physician's Initials

or Born before 1/1/57 and therefore considered immune

MMR (Measles-Mumps-Rubella) If given instead of individual immunizations

Dose one _____ Date of Vaccination

Dose two _____ Date of Vaccination

*In accordance with New York State Health Code, applicants born on or after January 1, 1957 must show documentation of two vaccination dates for Rubella.

We would appreciate it if you would complete this form as soon as possible as applicant may not begin working until this form has been received. All responses will be treated in strict confidence. Please return form to applicant or mail to:

SLR Crime Victims Treatment Center
411 West 114th Street, Suite 2C, New York, NY 10025

The applicant's signature below represents permission for you to provide us with the above information.

Applicant's Signature

Date: _____

Physician's Signature

Date: _____

Thank you very much!