



100 Madison Avenue
 P.O. Box 1956
 Morristown, NJ 07962-1956
 P: 973-971-5475
 F: 973-290-7259

PATIENT ID
 HERE

HEALTH CERTIFICATE
(For Volunteers Born Before 1956)

Volunteer Applicant Name: _____

Address: _____

Telephone Number: (_____) _____ DOB: ____/____/____

1. Health Status: To my knowledge this applicant:

a. Is free from contagious disease and capable of performing all volunteer assignments at an Atlantic Health hospital.

Yes _____ No _____

b. If no, please list what precautions need to be taken and if the volunteer has any restrictions in her or his activities: _____

2. Tuberculosis Testing: If you have ever placed a Mantoux Test (PPD) on this patient, please record the two most recent test dates and results. If positive, please provide documentation of a chest x-ray.

Date: mo/day/yr	Amount	Result (mm)
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1. _____

2. _____

3. Hepatitis B Vaccine: *This test is optional.* If you have given this patient the Hepatitis B vaccine, please record the dates that it was given.

1st Dose ____/____/____ 2nd Dose ____/____/____ 3rd Dose ____/____/____

4. Doctor's Name: _____

5. Doctor's Signature: _____

6. Doctor's Address: _____

7. Doctor's Phone Number: (_____) _____