VOLUNTEER MEDICAL STATEMENT

I authorize the release of the following information to Saint Luke's Health System (SLHS).

Please return signed document to: ______________________________ ____________________
Location Name (listed on Page 1) Email or Fax Number

______________________ ______________________________ __________
Applicant Printed Name Applicant Signature Date

______________________ ______________________________ __________
Guardian Printed Name Guardian Signature (consent if under 18 yrs) Date

Please list any health concerns or limitations: ____

____

---------- This section to be completed by a Physician ----------

_____ I see no medical reason why this person should not volunteer.

_____ This person should volunteer with the following restrictions:

____

_____ It is not recommended for this applicant to volunteer.

______________________ ______________________________ __________
Primary Care Provider (print) Signature Date

______________________________ ______________________________
Address Phone

saintlukeskc.org
Saint Luke's Health System is an Equal Opportunity Employer. Services are provided on a nondiscriminatory basis.