WESTERN MARYLAND HEALTH SYSTEM
VOLUNTEER HEALTH APPRAISAL

Volunteer: Please complete Part I of this form to the best of your ability. **Part II requires a physician's signature**. All volunteers must receive skin test for tuberculosis (PPD). Per CDC guidelines-----If you have not had a PPD in the past 12 months, then we will do a second PPD one week after first. Employee Health will do this at no cost. Any questions, please contact Employee Health at 240-964-8210.

Volunteer Part I

Name:_____ **Birth Date:_____**

Address:_____ Phone_____Assignment_____

Immunization Record/History(to be completed by volunteer)

A. Measles(Rubeola)
- ( ) Had disease — Date(year)_____
- ( ) Immunized with vaccine (2 doses required) — Date(s) _____/_____
- ( ) Positive immune titre — Date_____

B. German Measles (Rubella)
- ( ) Had disease — Date(year)_____
- ( ) Positive immune titre — Date_____
- ( ) Immunized with vaccine — Date(s)_____/_____

C. Mumps
- ( ) Had disease — Date(year)_____
- ( ) Immunized with vaccine (2 doses required) — Date(s)_____/_____

D. Polio
- ( ) Completed primary immunization series — Date(year)_____

E. Chickenpox (Varicella)
- ( ) Had disease — Date(year)_____
- ( ) Immunized with vaccine (2 doses required) — Date(s)_____/_____
- ( ) Positive immune titre — Date_____

F. Tetanus-Diphtheria or Tdap(with one time dose of Pertussis) (date of most recent)Date_____

G. PPD-Skin test for Tuberculosis (will be applied by Employee Health) Date_____Result_____
( ) History of positive PPD (chest x-ray results required)

H. Hepatitis B Vaccine Series # of doses_____ Date completed_____
(ONLY NEEDED FOR HOSPICE VOLUNTEERS)

I. Influenza Vaccine Date_____
WMHS has a mandatory flu vaccine policy. Yearly flu vaccine documentation is required to volunteer.

I hereby authorize my physician to release any medical information in my record relating to my ability to function as a volunteer for the Western Maryland Health System. I certify that the above information is accurate, as far as I am aware.

Volunteer/Parent Signature_____Date_____

Part II Physician/Health Examiner Part

_____ has been evaluated by me and to the best of my knowledge is free of communicable disease, and has no problems that may interfere with his/her ability to function as a volunteer for the Western Maryland Health System.

Physician or Health Examiner Signature_____ Date_____