



Family Lifeline Volunteers

A Ministry of the Little Sisters of the Assumption

MEDICAL CERTIFICATION FORM

To be filled out by Prospective Volunteer's current primary care physician.
Please type or print clearly.

Applicant's Name : _____

Address _____

Have you been the applicant's regular physician? Yes _____ No _____

If so, how long? _____

GENERAL INFORMATION

General Appearance _____

Explain any physical abnormalities _____

PAST HISTORY

Past Hospitalizations (including surgeries) _____

History of drug abuse: _____

History of alcohol abuse _____

Significant past illness: _____

FAMILY HISTORY (significant medical/psychiatric): _____

CURRENT INFORMATION

Medicines (including recurrent non-prescriptions): _____

Significant present medical problems: _____

Allergies: _____

Dietary Restrictions: _____

Tobacco/alcohol use: _____

Physical restrictions: _____



"One heart, one family..."

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GENERAL PHYSICAL

Weight. _____ Height. _____ B.P. _____ P. _____

Lab(if done recently): U/A _____ CXR _____ CBC _____

Mantoux (PPD)Test _____

(Note: Please use (-) for normal and (+) for abnormal)

General Appearance _____ Eyes _____ Ears _____ Nose _____ Mouth _____

Adenopathy _____ Chest _____ Breast _____ Heart _____ Abdomen _____

Genitals _____ Rectum _____ Skin _____ Neurological _____ Medical status _____

Please substantiate any abnormalities noted above _____

I recommend this patient to live in community and work for the Family Lifeline Volunteers in their social service programs. YES _____ NO _____

Reservations or Reasons: _____

Physician _____ **Date** _____

Signature

***Printed name and address of Physician's office** _____

***Physician's Phone** _____

*(*Required for verification purposes)*

**Please return form to: Alice R. Finley, Family Lifeline Volunteers, Inc.
100 Gladstone Avenue, Walden, New York 12586**