



**Availability:** Please note hours available in appropriate spaces.

	Sunday	Monday	Tuesday	Wednes	Thurs.	Friday	Sat.
Time Available							

(Actual commitment time will be determined during interview with the Coordinator of Volunteer Services)

**I agree to abide by the requirements and regulations of Palisades Medical Center and the service to which I am assigned. I will serve a minimum of sixty hours (60) after participating in required training. Letters or recommendation will be not issued prior to completion of 60 hours of volunteer time.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Parent's Agreement:**

My son/daughter \_\_\_\_\_ is 14 years of age or older and has my permission to volunteer at Palisades Medical Center. I realize the responsibilities of this position and will cooperate to help him/her to comply.

In the event that my child becomes ill or injured while volunteering and I cannot be reached, I hereby give my consent to have him/her treated by a staff physician.

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**For Office Use Only:** ID # \_\_\_\_\_

Assignment: \_\_\_\_\_ Start Date: \_\_\_\_\_

**Day(s) & Times Assigned:**

Mon. \_\_\_\_\_ Tues. \_\_\_\_\_ Wednes. \_\_\_\_\_ Thurs. \_\_\_\_\_ Fri. \_\_\_\_\_

Sat. \_\_\_\_\_ Sun. \_\_\_\_\_

Uniform Issued \_\_\_\_\_ Badge Issued \_\_\_\_\_

Deposit Received \_\_\_\_\_

**Exit Interview:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Palisades Medical Center

New York Presbyterian Healthcare System

## VOLUNTEER SERVICES DEPARTMENT PHYSICIAN'S CONSENT FORM

Dear Dr. \_\_\_\_\_:

\_\_\_\_\_ is interested in becoming a volunteer at  
Palisades Medical Center.

Are there any limitations (physical or mental) that would prohibit this service?

Yes \_\_\_\_\_ No \_\_\_\_\_ if yes, please explain limitations.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DOCTOR PLEASE DOCUMENT HISTORY OF DISEASE OR VACCINES  
RECEIVED if patient was born in 1957 or later.**

**Immunizations:**

Mumps \_\_\_\_\_  
Measles (Rubeola) \_\_\_\_\_  
German Measles (Rubella) \_\_\_\_\_  
Chickenpox (Varicella) \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature (Please attach Professional Card or Stamp)

Please return to:

Palisades Medical Center  
Coordinator of Volunteer Services  
7600 River Road  
North Bergen, NJ 07047

Sincerely,

Denise Whitley  
Coordinator Volunteer Services

I have given permission for the release of the information requested.

\_\_\_\_\_  
Volunteer's Signature

*Affiliated with Columbia University College of Physicians & Surgeons*

7600 River Road • North Bergen, New Jersey 07047 • 201-854-5000

