McLeod

Regional Medical Center

March 1, 2019

Thank you for your interest in becoming a junior volunteer at McLeod Regional Medical Center. We are proud of our eight-nine week summer program and the many experiences it offers. We ask that as a junior volunteer our students make a commitment to their volunteer duties and abide by all rules and guidelines that are given. We also ask that they constantly strive to exhibit a caring and compassionate attitude to all who come to McLeod for treatment, as well as, those you come in contact with while on site.

Please read the following requirements for the Junior Volunteer program:

1. You must be 13-years-old by May 1, 2019.

2. You must have an overall "B" average in all of your courses in school. We will need a **copy of your last report card.**

3. If accepted for this program, you will receive a tuberculin screening (free of charge). The screening is a blood test that will be done at McLeod Occupational Health Services. If you do not complete the test you will not be eligible to participate in our Junior Volunteer program.

   Enclosed is a TB Blood Test release form which needs both your signature and a parent and/or a guardian signature.

4. You must submit the following to complete your application:
   - ✓ **Three letters of recommendation from professionals: i.e. guidance counselor, pastor, or teacher.**
   - ✓ **The enclosed preference sheet indicating where you would like to volunteer.**
     - ➢ Please know that there is no guarantee that you will be assigned to your 1st preference.
     - ➢ Assignments are made based on position availability in the participating departments.
   - ✓ **A one-page essay on the reason(s) why you would like volunteer at MRMC this summer.**
   - ✓ **A copy of your recent immunization record**
   - ✓ **A copy of your latest report card**
   - ✓ **Parental/guardian signature is required on application.**
   - ✓ **Marketing (Photo) release form**

5. You must volunteer a minimum of 50 hours during the 8-9 week period of June 5-August 2.
    - Documentation of hours will only be provided to those students who complete 50 hours or more.

6. All information must be submitted no later than **Monday, April 1, 2019.** **INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.**

There are limited availabilities in the program. A committee from the Auxiliary Board will review all applications received. Accepted applicants will be notified of the next steps in the application process.

We look forward to hearing from you very soon. If you have questions regarding the application process, please feel free to call me at (843)777-2234.

With our mission in mind,

Linda Boone, Director
Volunteer Services and Gift Shops

LB:skb

Enclosures: Application, TB Permission Form, Badge Request Form, Preference Sheet, Marketing (Photo) Release

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YOUR CHECKLIST:

_____ Application completed and signed w/ parental/guardian signature
_____ Recommendation letters (3)
_____ Signed tuberculin screening form
_____ ID Badge form
_____ Preference sheet
_____ One page essay
_____ Copy of latest report card
_____ Signed Marketing Release form

All of this information must be turned in to the Volunteer Services office no later than **MONDAY, APRIL 1, 2019.**

NOTE: Please be aware that a number of junior volunteering assignments will be in buildings located outside the main hospital or Pavilion. These assignments will require walking some distance and/or crossing streets.

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JUNIOR VOLUNTEER APPLICATION

TO BE COMPLETED BY THE APPLICANT:

Name:_____ **Phone (Ho):**_____**(Cell):**_____

Address:_____ **City:**_____ **State:**___ **Zip Code:**_____

Email address_____

Date of Birth: Month_____ **Day**_____ **Year**_____

T-Shirt Size: S M L XL 2XL

What school do you attend?_____ **Grade Entering:**_____

List school and church activities: _____

_____

Please list honors and awards you have received at your school, church or civic organizations:

_____

Have you ever volunteered before? Yes_____ No_____ If yes, where and what did you do?

_____

Are you interested in a health related career? If so, what are your interests?

_____

Do you have a B average in your course work at school? Yes_____ No_____

Please submit a copy of your latest report card with your application. _____

TO BE COMPLETED BY PARENT OR GUARDIAN:

Name_____

Address (if different from applicant) _____

Employer:_____**Work Phone No.:** _____

In case of emergency, we should notify_____

Phone: _____

(Please complete other side)

PARENTAL/GUARDIAN AGREEMENT:

I, the parent and/or guardian of _____, join with my teen in consenting to her/his participation in the McLeod Regional Medical Center Junior Volunteer program. This program will be conducted under both the leadership and the guidance of the Volunteer Services Department.

Parent/Guardian Name (Print):_____

Parent/Guardian Signature:_____

Date:_____

TEEN AGREEMENT:

As a junior volunteer, I understand that confidentiality is not only important, but it is required. Any junior volunteer who releases any patient information will be released immediately from the program. I understand that under HIPAA regulations, junior volunteers are personally liable under Federal law to know and follow our confidentiality policy. I will be instructed in both the values and the mission of the medical center, and my behavior will always reflect these values.

Junior Volunteer Applicant Name (Print):_____

Junior Applicant Signature:_____

HEALTH INFORMATION:

Do you have any limitations which may require a special work assignment? Yes_____ No _____

If yes, please give details _____

_____

_____

PLANNED ABSENCES:

Please note any planned absences that you know are scheduled for June-July (i.e. vacation, camp, etc.):

_____

_____

_____

Revised 1/17, 6/18, 2/19

JUNIOR VOLUNTEER PREFERENCE SHEET
FOR WORKING HOURS AND AREAS OF WORK

NAME:_____
(Please print)
PHONE NUMBER:_____

You will be assigned to work two mornings, two afternoons, or one full day per week, unless you specify differently. We will do our best to assign you to the areas you are most interested in and on the days you specify.

I am able to work on the following days: (circle)

Mon Tues Wed Thurs Fri

I would like to work the following hours: (circle all that apply)

Mornings: 8:30 a.m. – 12:30 p.m.

Afternoons: 12:30 – 4:30 p.m.

Full days: 8:30 a.m. – 4:30 p.m.

Please check the areas that interest you. Volunteer placement depends on the needs and requests of the hospital departments.

____ Children/child care
____ Clerical/computer
____ Gift Shop work
____ Patient contact/care
____ Physical or occupational therapy
____ Flower delivery to patients/front desk assistance
____ Patient transport
____ McLeod Fitness programs @ McLeod Health & Fitness
____ Greeting visitors and escorting them to their destinations
____ Reception/waiting areas
____ Nutrition services

Please specify any area in which you are interested in that is not listed:_____

_____

McLEOD EMPLOYEE HEALTH SERVICES
555. E. CHEVES STREET
FLORENCE, SC 29501

I hereby give McLeod Employee Health Services my permission to perform a tuberculin assessment on my son/daughter consisting of:

TB Blood Test and/or Chest X-ray, if indicated

A TB blood test will be given free of charge. The student must go to Employee Health Services to be tested. Screenings will be on May 1-17 (Tue-Fri) by appointment only. The test results may take 7-10 days.

The TB blood test must be completed by May 17, 2019 . If the student does not complete the test before this date he/she will be not be eligible to participate in the Junior Volunteer program.

If the results of the blood test are positive, I understand that my son/daughter will be asked to have a chest x-ray in Employee Health Services and any follow-up that is medically indicated by the chest x-ray results. There will be no charge for these services, if required. Upon completion of the TB assessment, Employee Health Services will issue a medical clearance, and my son/daughter will be allowed to begin his/her volunteer service.

Junior Volunteer's Name_____
(Please print)
Date of Birth:_____

Parent's Signature:_____

Date:_____

Employee Health Services Office Hours:
Monday-Friday 8:00 a.m. - 5:00 p.m.
(843)777-5146

JR VOLUNTEER:
____ New
____ Returning

McLeod Health
The Choice for Medical Excellence.

NON-EMPLOYEES ID CARD AUTHORIZATION

Social Security #:_____ Birth Date: _____

Legal First Name: _____ MI:___ Last Name:_____

Preferred First Name:_____ Name Suffix: ☐II ☐III ☐IV ☐V ☐JR ☐SR

Gender: ☐ M ☐ F Ethnicity:☐3 Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐1 White ☐2 Black/African American ☐4 Asian ☐5 American Indian/Alaskan Native ☐7 Native Hawaiian/Other Pacific Islander

Address 1: _____

Address 2: _____

City:_____ State:_____ Zip Code:_____

County:_____ Telephone Number:_____

School/Sponsoring Organization: _____

TO BE COMPLETED BY MANAGER/SUPERVISOR:

☐ McLeod Health ☐Behavioral Health ☑MRMC ☐MPA ☐MMC-Darl ☐ MMC-Dil ☐MH&F ☐ FDTN ☐ Home Health

Department #: 18325

Job Code # : 11922
(Job Code Listing on back)

Nonemployee Type: ☐ Contract Staff ☐ Medical Staff ☐ Physician Employed Personnel ☐ Board Member ☑ Volunteer ☐ Clergy ☐ Nonclinical Consultant ☐ Student ☐ Instructor ☐ Other

Start Date: / / Stop Date: / / Approved Credentials: _____

Print Name Manager/Supervisor: Linda Boone

FTE assigned to this position: ___.___ Employee Status: NE

Manager/Supervisor Approval:_____
Signature (date)

OSHA Code ☐1= Exposure ☐ 2= No Exposure ☐ 5= Computer Access Only

TO BE COMPLETED BY HUMAN RESOURCES:

Applicant #: _____ Employee Number: _____

Supervisor Code:_____ Department Director:_____

Human Resources Representative:_____ Date_____

Human Resources Specialist:_____ Date_____
(Keying/Data Entry)

JR VOLUNTEER
(Photo Release)

McLeod Health

The Choice for Medical Excellence

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
FOR MARKETING AND PUBLIC RELATIONS PURPOSES

Participant Name: _____ *Date of Birth: _____

Address: _____

_____

* = optional

I authorize _____ (Provider) to use or disclose my "protected health information" (PHI) to:

Recipient Name	Address	City	State	Zip

☐ My medical prognosis ☐ Only general one-word condition ☐ My city, county or state

☐ My age ☐ Date/Time of expected or actual discharge

☐ Information about my specific injuries or medical condition

☑ Information to conduct an interview with me or take a photograph of me for a future McLeod publication

☑ Use of my photograph, audio, testimonial, or appearance in filming or in print for publication by McLeod Health

☑ Use of my photograph, audio, testimonial, or appearance in video for Social Media purposes

☐ Other (please specify): _____

Purpose(s): _____

☐ The requested use or disclosure involves marketing for McLeod Health. This marketing use or disclosure ☐ will or ☑ will not involve remuneration to McLeod Health. An example of "remuneration" includes receiving money or some other form of compensation in exchange for the marketing use or disclosure.

A.) I understand that PHI may include records disclosed by health care providers and facilities that previously provided treatment to me.
B.) I understand that PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment) and/or State Law (such as mental health, AIDS or HIV).
C.) I understand I may revoke this Authorization at any time however the revocation will not apply to PHI that has already been used or disclosed pursuant to this authorization. Contact the Privacy Official to initiate the revocation procedure.
D.) I understand that McLeod Health will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
E.) I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy standards.
F.) I understand that this Authorization will expire in 90 days after it is signed unless another date is specified here indefinite.

I have read and understand this Authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on the Patient's behalf. I hereby release the Provider (as named above) from any liability or damages arising in connection or related to with the use and/or disclosure of my protected health information pursuant to this Authorization.

Marketing Staff Representative	Signature	Date

X _____ X _____ _____

Print ~~Patient~~ Name (Student) ~~Patient~~ Signature Date

X _____ X _____ _____

Authorized Representative (Parent) Relationship to ~~Patient~~ (Student) Telephone Number

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