McLeod

Medical Center Dillon

Thank you for your interest in becoming a teen volunteer at McLeod Health. We are proud of our summer program and the many experiences it offers. We ask that as teen volunteers you make a commitment to your volunteer duties and abide by all rules. We also ask that you constantly strive to exhibit a caring and compassionate attitude to all who come to McLeod for treatment and with whom you come in contact. Please read carefully the following requirements for volunteering at McLeod this summer.

1. You must be 15 years old by May 1, 2021

2. You must have a "B" average in all of your courses in school. We will need a copy of your last report card for the year.

3. If accepted for this program, you will receive a tuberculin screening (Blood test at no charge to you). Enclosed is your tuberculin screening form which must be completed and signed by you and one of your parents. Signing the screening form gives approval for the tuberculin screening. Please return these forms along with a copy of your immunization record.

4. Submit a letter of recommendation from your guidance counselor, pastor or teacher, the enclosed reference sheet indicating where you want to volunteer, and a one-page essay on the reasons you want to volunteer at McLeod this summer.

5. The uniform consists of white or khaki long pants or khaki skirt, and white shirt. The shirt will be provided by the hospital at a $15 fee. Please bring $15.00 to purchase your white polo shirt.

6. All information must be submitted no later than **Friday, May 7, 2021 at 4:00 PM**. We are limiting the number of volunteers, so this deadline will be strictly enforced.

We look forward to hearing from you soon. If you have questions regarding the application process, please feel free to call me at 487-1293.

Sincerely,

Candice Tyler
Clinical Patient Representative
Teenage Volunteer Coordinator

Enclosures: TB Permission Form

YOUR CHECKLIST

____ Completed and signed Application
____ Recommendation letter
____ Signed tuberculin screening form
____ One-page essay
____ Copy of immunization record

____ Copy of report card

All information must be in our office no later than May 10.

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Teen Volunteer Application

To Be Completed by the Applicant:

Name _____ Phone Number _____

Address _____ City, State _____ Zip Code _____

Date of Birth _____ Age _____ Social Security Number _____

What school do you attend? _____ Grade _____

List school and church activities

_____

_____

_____

_____

List honors and awards you have received at your school or church

_____

_____

_____

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?

_____

To Be Completed by Parent or Guardian:

Name _____

Address (if different from Applicant): _____

Employer _____ Phone Numbers _____

In case of Emergency, we would notify _____ Phone _____

Parental Agreement

We, the parents of _____, join with our teen in consenting to his/her participation in the McLeod Medical Center Dillon Teenage Volunteer Program. This program will be under the leadership and guidance of Nursing Administration.

Parent Signature _____ Date _____

Teen Agreement

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

Teen Applicant Signature _____ Date _____

Health Information

Have you ever had Chicken Pox? Yes ____ No ____

Have you had MMR (Measles, Mumps, Rubella) vaccine in the last three years? Yes _____ No _____ If so, when?

Do you have any limitations that may require a special work assignment? Yes _____ No _____ If yes, please explain: _____

Are you taking medicine on a regular basis? Yes ____ No _____ If yes, please list

_____

Name / Phone Number of your personal physician _____

Teen Volunteer Preference Sheet

Teen Volunteer Name _____

CHOOSE YOUR TOP THREE PREFERENECES BY PLACING NUMBER 1, 2 OR 3 ON LINE

Nursing:

- Emergency _____
- Intensive Care Unit _____
- Medical/Surgical Unit _____
- Women's Services _____
- Same Day Surgery _____

Nutrition Services _____

Radiology _____

Laboratory _____

Marketing and Public Relations _____

Rehab Services:

- Cardiac Rehab _____
- Physical Therapy _____

Respiratory Care _____

Other (Write in Area of Interest) _____

McLeod Medical Center Dillon
301 E. Jackson Street
Dillon, SC 29536

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 McLeod Medical Center Dillon to be tested. Screenings will be on May 21-25 (Mon-Fri) between 8:30am and 3:00pm. The test results may take 7-10 days.

If the results of the blood test are positive, I understand that my son/daughter will be asked to have a chest x-ray at McLeod Medical Center Dillon 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:_____

Pam Strickland
McLeod Dillon Employee Health
(843)487-1361