March 8, 2021

Thank you for your interest in becoming a teen volunteer at McLeod Health. We are proud to begin 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. Teenage Volunteers be 14 years old by May 1, 2021

2. Teenage Volunteers must provide a Letter of Recommendation from teacher

4. Teenage Volunteers must provide a current immunization record.

5. Teenage Volunteers must purchase a uniform. The uniform consists of khaki long pants, skirt, and a white polo shirt.

7. After submission of your application, you will be contacted to schedule a tuberculin screening (Blood test-at no charge to you). If you have questions regarding your application, you can contact Becka Wade (843) 366-2821.

Sincerely,
Jaime Schwartz
Volunteer/ Gift Shop Manager
McLeod Loris Seacoast

---

**YOUR CHECKLIST**

____ Application completed and signed
____ Signed tuberculin screening consent
____ Copy of immunization record
____ Letter of Recommendation

We look forward to hearing from you soon. If you have questions regarding the application process, please feel free to call me at 843-366-2018 or
Email jaime.schwartz@mcleodhealth.org

## TEEN VOLUNTEER APPLICATION

**TO BE COMPLETED BY 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** _____________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

**Please 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?** ___________

---

**Please check off the location you are interested in.**

**McLeod Loris** _______ **McLeod Seacoast** _______

**TO BE COMPLETED BY PARENT OR GUARDIAN:**

**Name**

_____________________________________________________________________________

**Address (if different from applicant)** ____________________________________________

**Employer** ____________________________________ **Work Phone Number** __________________

**In case of emergency, we would notify** _____________________________ **Phone** _______________

**(Please complete other side)**

Created 4/3/18 JS

## PARENTAL AGREEMENT

We, the parents of ______________________________, join with our teen in consenting to her/his participation in the McLeod Loris Teen Volunteer program. This program will be under the leadership and guidance of Nursing Administration.

Parent ______________________________ 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 ______________________________ Date ______________________

## HEALTH INFORMATION:

Have you had Chicken Pox? Yes __________ No __________

Have you had MMR (measles, mumps, rubella) vaccine in the last three years? If so,

when? ______________________________

Do you have any limitations which may require a special work assignment? ________________

If yes, please give details ______________________________________________

Are you taking medicine on a regular basis? Yes __________ No __________

Please list ______________________________________________

Name of your personal physician ______________________ Phone ________________

**McLeod Health**
*The Choice for Medical Excellence.*

*PLEASE PRINT YOUR INFORMATION*

# 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:_______________

Email: _______________

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 #: _______________

Job Code # : _______________

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

Start Date: __/__/__ Stop Date: __/__/__ Approved Credentials: _______________

Print Name Manager/Supervisor: _______________

FTE assigned to this position: ___.___

Manager/Supervisor Approval:_______________
Signature (date)

## TO BE COMPLETED BY HUMAN RESOURCES:

Applicant #: _______________ Employee Number: _______________

Supervisor Code:_______________ Department Director:_______________

Employee Status:___NE_____

## CONFIDENTIALITY STATEMENT

I understand and agree that in the performance of my duties as a teen volunteer of McLeod Loris Seacoast, I must maintain confidentiality of patient records, employee records and all other medical center data which are considered confidential and restricted in use. Further, I acknowledge that I have received a copy of the medical center's confidentiality policy and I have either read it or had it read to me, and I understand it.

______________________________________________

Signature of Volunteer Date

# McLeod Health

## The Choice for Medical Excellence

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

Patient/Participant Name: ______________________ *Date of Birth: ______________

Address: ______________________ *SS # ______________

______________________ *Patient# or MR#: ______________

* = 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______________.

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 |
| Print Patient Name | Patient Signature | Date |
| Authorized Representative | Relationship to Patient | Telephone Number |

Rev. 01/16

**McLeod Health**

**Today's Date** ____________

| Patient Name: | | | Age | Date of Birth | SS# | Race | Sex |
|---|---|---|---|---|---|---|---|
| Address | | City | | State & Zip Code | | Marital Status | |
| Home Number | Cell Number | Occupation or Job Title/Dept Name | | Emergency Contact- Name & Number | | | |
| Company/Employer Name | | | | Authorized Company Contact: | | | |
| Address | | | | Phone Number: | | | |

**FOR INJURIES or ILLNESS, PLEASE COMPLETE THE FOLLOWING:**

| SPECIFIC PART OF BODY INJURED: | TIME OF INJURY: | DATE OF INJURY: |
|---|---|---|
| BRIEFLY EXPLAIN WHAT HAPPENED: | | |

1. **AUTHORIZATION AND AGREEMENT FOR TREATMENT:** I hereby give my consent for the treatment considered necessary to the McLeod Regional Medical Center, for the patient whose name appears above, under the care of the attending Employee Occupational Health physician, his associates, partners, assistants or designees. I consent to the medical care, which may encompass necessary laboratory, diagnostic, or medical treatment and procedures which the Employee or Occupational Health physician, his associates, partners, assistants, or designees may deem necessary or advisable during my visit. I realize this examination is not an in-depth or comprehensive exam and is intended solely for the specific purpose of a pre-placement, annual assessment, fitness for duty, or injury examination. It is not intended to take the place of a routine or preventive examination by my private physician. I hereby certify to the accuracy of the information provided above. Also, I have read the above consent and understand the same and certify that no guarantee or assurance has been made as to the results, which may be obtained. **I authorize the Medical Provider to access my prescription information via the South Carolina Prescription Monitoring Program (PMP) at his/her discretion. This authority is granted under S.C. Code Ann. § 44-53-1640(A) to establish and maintain a program to monitor the prescribing and dispensing of all Schedule II, III, and IV controlled substances by professionals licensed to dispense these substances in this state.**

2. **AGREEMENT TO PAY FOR SERVICES:** in the case the illness/injury is not covered by Workers' Compensation. For consideration and treatment provided to the patient, I agree to pay McLeod Employee or Occupational Health Services all charges for services rendered to myself or the patient. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate.

3. **DRUG/ALCOHOL TEST RELEASE:** I give my consent to McLeod Employee or Occupational Health Services to collect from me either breath, blood, hair, saliva or urine samples in order to comply with my employer's drug or alcohol testing program. Furthermore, I authorize McLeod Employee or Occupational Health Services to submit a sample of my breath, blood, hair, saliva or urine for analysis. I understand that a copy of the lab results will be reported to the company's medical review officer and that the test results will be reported to company management for program compliance purposes.

   I understand that my records are protected under the Federal and State confidentiality regulations and cannot be released without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at anytime unless action has already been taken based upon it and that in any event, this consent expires automatically one year from the date of this form. ***I also certify that the urine specimen which I am providing is mine and has not been altered in any manner.***

   ☐ Photo I.D. or ☐ Signature Card

**McLeod Health**

**Today's Date** ________

**4.** **ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES:** I hereby acknowledge I have received a written copy of the McLeod Health Notice of Privacy Practices which sets forth the ways in which my protected health information may be used or disclosed by McLeod Health, and outline my rights with respect to such information. I also acknowledge that I have been allowed to ask questions. If I am not the patient, I represent I am authorized by law to act for and on the patient's behalf.

**TO REQUEST MEDICAL RECORDS OR OTHER PROTECTED HEALTH INFORMATION (PHI) PLEASE COMPLETE THE BACK OF THIS FORM; I HAVE READ AND UNDERSTAND THIS FORM. IF YOU HAVE QUESTIONS, PLEASE ASK THE RECEPTIONIST.**

| ______________________ | ______________________ | ____________ |
|---|---|---|
| Print Patient or Guardian Name | Patient Signature | Date |

## (Back of Form)

## COMPLETE FOR THE RELEASE OF RECORDS ONLY:

| Patient Name: | | Date of Birth | SS# |
|---|---|---|---|
| Address | City | | State & Zip Code |

### 4. AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

*(check all that apply)*

☐ I authorize McLeod Employee or Occupational Health Services to disclose, written or verbal, my "protected health information" (PHI) to my employer or in the case that I am here for a physical, to release information to my future employer.

☐ I authorize ______________________________ to disclose my "protected health information" (PHI) to McLeod Employee/Occupational Health- 555 East Cheves Street- Florence, SC 29506. Office (843) 777-5146 Fax (843) 777-5159.

☐ I authorize McLeod Employee or Occupational Health Services to disclose my "protected health information" (PHI) to:

| Recipient Name | Address | City | State | Zip |
|---|---|---|---|---|

☐ Entire record or Specify:______________________________

☐ Injury/Date of Injury: ______________________________

Information for treatment period: From (date)________________ To date)________________

**Purpose(s):** ☐ Legal Investigation ☐ Insurance ☐ Disability Determination ☐ Other____________ OR:

☐ I request my information to be released to me to exercise my right to access and obtain a copy of my PHI.

A.) I understand that PHI may include records disclosed by my 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 that I may revoke this Authorization at anytime 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 process.
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.

McLeod Health

Today's Date

______

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 ______.

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.

| ______ | ______ | ______ |
|---|---|---|
| Print Patient or Guardian Name | Patient Signature | Date |
| ______ | ______ | ______ |
| Authorized Representative | Relationship to Patient & Telephone Number | Date |