McLeod Health

The Choice for Medical Excellence

March 1, 2023

Dear Prospective Junior Volunteer,

Thank you for your interest in becoming a junior volunteer at McLeod Regional Medical Center. The Junior Volunteer Summer Program offers a unique opportunity for teen volunteers to share their gift of time and talents to benefit the lives of patients, families, and staff at McLeod Regional Medical Center, as well an opportunity of investment for your own development and growth. We are proud of our eight-week summer program and the many experiences it offers. We ask that as a junior volunteer our students 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 they encounter while on site.

Please read the following requirements for the Junior Volunteer program:

A. **Eligibility Age** - 13 to 17 years old. Student must be 13 years old on/by May 1, 2023.
B. **Grade Average** – Student must have an overall "C" average in all courses in school.
C. **Time Commitment** – Must commit to volunteer a minimum of 50 hours during the 8 weeks span.
D. **Returning Juniors** – If you are a returning Junior (you have already volunteered with us during the last summer) please ***do not*** use this form to re-apply; you will be contacted to submit your forms separately.

Important Dates:
Application Accepted: March 1 -April 5, 2023 (by 5:00PM)
Orientation: June 2, 2023 1:00 PM – 3:00 PM
Service Commitment: June 5 – July 28, 2023

Application Process – You must submit the following to complete your application.

1. **Complete the Junior Volunteer Application form** – Please make sure all contact information is current. The applications must be turned in **no later than Wednesday, April 5, 2023 by 5:00pm.**

- **Reference Letter** – Three letters of recommendation from professionals: i.e., guidance counselor, teacher, pastor, coach, or supervisor/employer.
- **Essay** – submit a one-page essay on the reasons (Why you would like to volunteer at McLeod).
- **Copy of recent immunization records** – Submit records from your physician or DHEC.
- **Copy of latest report card** – Must have an overall "C" average.
- **Marketing Release Form** – Must be completed & signed by student and parent/guardian. (For authorization to capture and use your photo).
- **Name Badge -** Non-Employee ID Card Authorization form – Please complete the top portion of this ID badge form & return. You will be contacted later when to have your picture taken. We recommend you do this on the same day as your TB screening appointment.
- **Health Clearance -** TB Test release form must be completed & signed by student and parent/guardian. 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 on a certain date. If you do not complete the test, you will not be eligible to participate in our Volunteer program.

- 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.
  - You can choose to volunteer 1 shift of 8 hours or 2 shifts of 4 hours per week.
  - Documentation of hours will only be provided to those students who complete 50 hours or more at the end of the 8 weeks.
  - Please be aware that a few junior volunteering assignments will be in buildings located outside the main hospital or Pavilion. These assignments will require walking some distance, crossing streets and/or located at Enterprise Drive and/or McLeod Health & Fitness Center.

- Due to the federal requirement issued by CMS, all McLeod Health clinical, non-clinical, new hires, volunteers, students, administrative, vendors and contract workers are required to be fully vaccinated. If you are fully vaccinated, Occupational Health will need a copy of your documentation; otherwise, you may receive your vaccination at OH. If you would like to request a medical/religious exemption, please contact our office for the proper form. Note: If you are granted an exemption, you will be required to wear a mask and a shield.

2. Welcome Packet - Once we receive your completed application forms, we will send you a welcome packet with dates and times of your next steps.
   - Schedule interview and complete all tasks by deadline provided in the welcome packet
   - Complete TB test and ID badge by the deadline provided in the welcome packet

3. Receive your Confirmation – This is the confirmation that you have been selected for the program. Applying to the program doesn't guarantee a place in the program. Students with incomplete documentation will not be considered for the program.

4. Education Training Booklet/Test: Once you are accepted for the program you will receive a booklet and questionnaire test in the mail. Please complete that test and bring with you to orientation.

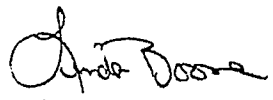
5. Orientation - Attendance is mandatory and only for students for the Summer Program. Orientation provides information about the hospital and the volunteer role. Privacy laws, safety codes, volunteer benefits, volunteer resources, dress code, policies and service agreement are all discussed. More information will be provided in the welcome packet.

6. Uniforms – Once you are accepted for the program you will receive a packet with details about the orientation and uniforms. All Junior Volunteers must wear their uniforms and badges while they are in the hospital volunteering. Polo shirts will be provided at orientation for a cost of $20.00. Payments can be made by cash or check made out to McLeod Volunteer Services.

7. Ready to start volunteering – You will receive your badges, department contact information, and uniforms at orientation and you will be ready to start volunteering per your schedule.

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 contact me at (843)777-2234 or Teresa Timmons at (843)777-2082 or via email at teresa.timmons@mcleodhealth.org.

With our mission in mind,



Linda Boone, CDVS
Director of Volunteer Services and Gift Shops
lboone@mcleodhealth.org

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

YOUR CHECKLIST:

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

All this information must be turned in to the Volunteer Services office no later than **Wednesday, APRIL 5, 2023.**

MRMC Volunteer Services
PO Box 100551 Florence
SC 29502-0551

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

McLeod

Regional Medical Center

Deadline: April 5, 2023

JUNIOR VOLUNTEER APPLICATION

Start date: June 5, 2023

TO BE COMPLETED BY THE APPLICANT: (Print) **Plan date to start:**___/____/____

First Name:_____ Last Name:_____

Preferred Name: _____ Date of Birth: ____/____/____ Age_____

Address:_____ City:_____ State:____ Zip Code:_____

Home Phone: ____-____-_____ Cell Phone: ____-____-_____ Gender: _____

Email address_____

T-Shirt Size: S M L XL 2XL 3XL

PARENT OR GUARDIAN

Father's Name _____ Cell Phone: ____-____-_____

Email address_____

Employer: _____ Work Phone: ____-____-_____

Mother's Name_____ Cell Phone: ____-____-_____

Email address_____

Employer: _____ Work Phone: ____-____-_____

In case of emergency, contact:

Name _____ Relationship _____ Cell Phone: ____-____-_____

Name of school you attend: _____ Grade Entering:_____

List school, church and Community Activities, Clubs: _____

_____

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 C average in your course work at school? Yes_____ No_____

How did you hear about our program?

☐ Family/Friend ☐ McLeod Health Website ☐Online/ Social Media ☐Newsletter/flyer ☐School ☐ Other

(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:_____

Date:_____

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, 2/20, 2/21, 2/22, 2/23

JUNIOR VOLUNTEER PREFERENCE SHEET
FOR WORKING HOURS AND AREAS OF WORK

NAME: _____
(Please print)
PHONE NUMBER: _____

We will do our best to assign you to the areas you are most interested in and on the days you specify. However, we must have an open position from that department. All volunteers will be required to complete a **minimum of 50 hours** to return during the school year or the next Summer.

Can you commit to the 50 hours minimum for the 8-week program? Yes ___ No ____

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 p.m. – 4:30 p.m.

Full days: 8:30 a.m. – 4:30 p.m.

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

I am interested in volunteering in this area:

____ Clerical
____ Clinical
____ I will take any open position

_____ Florence Campus _____ Business Support Services Campus (Enterprise Drive)
_____ MACK (McLeod Activity Center for Kids located at McLeod Health & Fitness Center)

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

_____

_____

McLeod

Regional Medical Center

POSSIBLE JUNIOR VOLUNTEER OPPORTUNITIES

Accounting
Admitting
Bio Med
Cardiac Rehab
Child Development Center
Children's Hospital
Clerical/Computer (Filing)
Clinical (Nursing Floors)
Day Hospital
Emergency Department
Engineering (Maintenance)
Environmental Services (EVS)
Front Desk Assistance
Gift Shop
Home Health
Human Resources
Laundry
McLeod Activity Center for Kids (MACK) @ Fitness Center
Marketing
Medical Records
Musicians
Nutrition Services
Patient Transport
Pharmacy
Procurement
Radiology
Reception/Waiting areas
Registration
Risk/Quality Management
Physical or Occupational therapy
Respiratory Therapy
Service Excellence
Wayfinding (Greeting visitors and escorting them to their destinations)
And more…

We do our best to assign you at your requested location, however due to high requests in some departments that is not always possible.

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Reference Form

Name of Volunteer Applicant:_____
Reference Name:_____
Reference Email:_____
Reference Phone Number:_____

The above referenced applicant has applied to our McLeod Junior volunteer program. We would appreciate your honest assessment as to their maturity, skills, and abilities. Thank you for taking the time to fill out this form. Once completed, please place in an envelope, and give to the applicant or scan and email to teresa.timmons@mcleodhealth.org. Your promptness would be appreciated as we cannot start the process of onboarding until all references are received. If you have any questions or would rather discuss this applicant over the phone, you can call Volunteer Services at 843-777-2082.

Thank you.

1. How long have you known the applicant?_____

2. In what context do you know the applicant? (Work, school, employer, church)_____

3. Do you feel the applicant will be an asset to our volunteer department? _____

4. Please describe what skills or characteristics the applicant possess that will be beneficial to our program? _____
_____
_____
_____

Please add any comments that you would feel would be helpful with our evaluation process:
_____
_____
_____
_____

Do you recommend this applicant for volunteering? ☐ Yes ☐ No

Signature:_____ Date:_____

Created: 02/23

McLEOD OCCUPATIONAL HEALTH SERVICES
McLeod Support Services Center
2210 Enterprise Drive
Florence, SC 29501

Name of Applicant: _____ **D.O.B:** _____

As a parent/guardian of the above minor applicant, I hereby give McLeod Occupational 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 and is a requirement for volunteer eligibility. The applicant must go to Employee Health Services to be tested. If you are unable to come during the dates below, please call Occupational Health at **(843) 777-5146** to schedule an appointment. You may go to Occupational Health the week of: **May 15-19 from 8:00am - 3:30pm.**

The TB blood test must be completed by May 24, 2023. If the applicant does not complete the test before this date, he/she will 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 Occupational 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.

Name of Applicant: _____

Applicant Signature: _____

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____

Date: _____

JR VOLUNTEER
(Photo Release)

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AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING AND PUBLIC RELATIONS PURPOSES
Created 09-11-2003 Reviewed 04-04-2018 Revised 07-01-2018

Volunteer 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): Volunteer Services - photos only

☐ 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 _____ Print Volunteer Name	X _____ Volunteer Signature	Date
X _____ Parent Signature	X _____ Relationship to Volunteer	Telephone Number

JR VOLUNTEER:
____ New
____ Returning

McLeod Health
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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-Dill ☐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

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TO BE COMPLETED BY HUMAN RESOURCES:

Applicant #: _____ Employee Number: _____

Supervisor Code:_____ Department Director:_____

Human Resources Representative:_____ Date_____

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