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 5, 2023

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 THREE letter of recommendations 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. A copy of your immunization record is required.

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. 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 for COVID. If you are fully vaccinated, Occupational Health will need a copy of your documentation; otherwise, you may receive your vaccination at McLeod Occupational Health. Please contact us with any questions.

7. All information must be submitted no later than **Friday, May 5, 2023 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 letters (3)
- Signed tuberculin screening form
- One page essay
- Copy of immunization record
- Copy of report card
- COVID vaccine record or declination form

All information must be in our office no later than May 5

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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 _____

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, 1/22

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 Friday, May 26 and Friday, June 2, 2023 between 7am and 9am. 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.

(Please print)
Junior Volunteer's Name_____

Date of Birth:_____

Parent's Signature:_____

Date:_____

Cynthia Rollins
McLeod Dillon Employee Health
(843)487-1361

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): Volunteer Services- Photos only

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 Volunteer Name	Volunteer Signature	Date
_____	_____	_____
Parent Signature	Relationship to Volunteer	Telephone Number

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: Candice Tyler

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