McLeod Health
Cheraw

Thank you for your interest in the McLeod Health Cheraw 2024 **Jr. Summer Volunteer Program**. The program is open to high school students ages 15-18 years old and will run from May 30 to July 26. We are proud of the many experiences it offers. We ask that as a Junior Volunteer you make a commitment to your volunteer duties and abide by all rules and regulations that are given. We also ask that you constantly strive to exhibit a caring compassionate attitude and heart while volunteering at McLeod Health Cheraw.

If you would like to be considered for a Jr. Volunteer position, please read the following requirements:

1. You must be 15 years of age by May 1, 2024.

2. You must at least have an overall "C" average or above in all school courses. 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. (Once accepted, an appointment will be scheduled with you and Occupational Health.)

4. You must submit the following on or prior to May 8, 2024:
    - A letter of recommendation from your guidance counselor, teacher and/or pastor
    - A one-page essay on the reason(s) why you would like to participate in the McLeod Health Cheraw Junior Volunteer Program
    - A copy of your most recent immunization record
    - A copy of flu vaccination documentation (if applicable)
    - A copy of Covid Vaccination documentation (if applicable)
    - A copy of your latest report card
    - A completed Jr. Volunteer Application signed by both you and your parent/guardian
    - A TB Blood Test and/or Chest X-ray consent form signed by both you and your parent/guardian

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) 320-5548 or email cassie.davis@mcleodhealth.org.

With our mission in mind,

Cassie T. Davis
Patient Experience Manager/Patient Representative

Enclosures: Jr. Volunteer Application and Tuberculin Consent Form

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YOUR CHECKLIST:

____ Completed Application with appropriate signatures
____ Recommendation Letter
____ Signed Tuberculin Consent Form
____ One Page Written Essay
____ Copy of current immunization record
____ Flu vaccination and Covid Vaccination documentation (if applicable)
____ Copy of latest report card
____ ID Badge Form
____ Marketing Release Form Signed

Finally, **MANDATORY** orientation will be held on Thursday, May 30 from 5:30 p.m. to 6:30 p.m. or Friday, May 31 from 1:30 p.m. to 2:30 p.m. with the volunteer and a parent/guardian after the application has been reviewed.

All information must be turned in to the Volunteer Coordinator by Wednesday, May 8, 2024.

- Turn in at the hospital front desk with attention to Cassie Davis or
- Mail to McLeod Health Cheraw
  Quality Department
  711 Chesterfield Highway
  Cheraw, SC 29520

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Junior Volunteer Application

TO BE COMPLETED BY APPLICANT

Name_____**Phone Number**_____

Address_____**City**_____**State**_____**ZipCode**_____

Email Address_____

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 and/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? Yes/No if so, what are your interests? _____

_____

TO BE COMPLETED BY PARENT OR GUARDIAN

Name_____ **Phone Number** _____

Address (If different from applicant) _____

Employer _____**Work Phone Number** _____

In case of emergency, we would notify _____

Phone Number_____ **Relationship** _____

(Please complete page 2)

PARENTAL AGREEMENT

I/We the parents of _____, join with our teen in consenting to his/her participation in the McLeod Health Cheraw Teen Volunteer Program. This program will be under the leadership and guidance of the Volunteer Services Department.

Parent Signature_____Date_____

_____Date_____

JUNIOR VOLUNTEER 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.

Junior Applicant Signature_____Date_____

HEALTH INFORMATION:

Do you have any limitations which may require special work assignment? Yes_____ No_____

If yes, please give details _____

Are you taking medication on a regular basis? Yes _____ No_____

Please list medications _____

_____

Name of your personal physician _____ Phone _____

PLANNED ABSENCES:

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

McLeod Health

Jr. Volunteer Tuberculin Assessment Consent

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

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

A TB blood test will be given free of charge. The test results may take 7 – 10 days.

If the student 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 ask 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 Name _____
(Please Print)

Date of Birth _____

Junior Volunteer Signature

_____

Parent/Guardian Signature

_____

Date _____

JUNIOR VOLUNTEER PREFERENCE SHEET
FOR WORKING HOURS AND AREAS OF WORK

NAME: _____
(Please print)
PHONE NUMBER: _____

We will do our best to allow shadowing/volunteering in 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 4 hours per week**.

Can you commit to the 4 hours minimum for the program? Yes ___ No ____

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

Mon Tues Wed Thurs Fri

I would like to volunteer 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.

Please check the areas that interest you on the attached sheet (minimum of 3). Volunteer placement also depends on the needs and requests of the hospital departments.

Please list any area in which you are interested in: _____
_____
_____

In addition to these shadow opportunities, Junior Volunteers will participate in hospitality and cleanliness rounds as well as assisting patients and families with signing up for MyChart.

McLeod Health
Cheraw

POSSIBLE JUNIOR VOLUNTEER OPPORTUNITIES

BioMed

Cardiac Rehab

Day Hospital

Emergency Department

Engineering (Maintenance)

Environmental Services (EVS)

Front Desk Assistance

Nutrition Services

Procurement

Radiology

Registration

Physical or Occupational Therapy

Respiratory Therapy

And more…

We do our best to assign you to 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 it to the applicant or scan and email to cassie.davis@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 843-320-5548.

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 possesses 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

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

JR VOLUNTEER:
____ New
____ Returning

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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 #: 16018

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: 5/30/24 Stop Date: 6/26/24 Approved Credentials:_____

Print Name Manager/Supervisor: Cassie Davis

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)