McLeod Health

The Choice for Medical Excellence

March 1, 2026

Dear Prospective Junior Volunteer,

Thank you for your interest in becoming a junior volunteer at McLeod Regional Medical Center. The Junior Volunteer Summer Program provides a distinctive opportunity for teen volunteers to contribute their time and talents to enhance the lives of patients, families, and staff at McLeod Regional Medical Center, as well an opportunity for investment for your own personal growth and development. Our volunteer program mission is to promote and provide exceptional patient experience by embodying the McLeod Health Mission, Vision & Values. We take pride in our eight-week summer program and the many experiences it offers.

Our volunteers donate their time and talent in a variety of service areas within McLeod Regional Medical Center, and our junior volunteer program serves as an excellent experiential learning opportunity! We require that as junior volunteers, our students adhere to all rules and guidelines provided and consistently strive to demonstrate a caring and compassionate attitude towards all individuals who visit McLeod for treatment, as well as those you encounter while on site.

Please review the following requirements for the Junior Volunteer program:

A. **Eligibility Age** - 13 to 17 years old; students must be 13 years old on or before May 1, 2026.
B. **Grade Average** – Students must have at least an overall "B" average in all courses in school.
C. **Time Commitment** – A commitment to volunteering for the **entire 8 weeks duration is mandatory**.
D. **Returning Volunteers** – If you are a returning volunteer, having volunteered previously, please ***do not*** use this form to reapply; you will be contacted to submit your forms separately.

Important Dates:
Application Accepted: March 1 - April 10, 2026
Submission Deadline: Friday, April 10, 2026 (by 5:00PM)
Mandatory Orientation: June 1, 2026, 1:00 PM – 3:00 PM
Service Commitment: June 1 – July 24, 2026 (**8 weeks**)

Application Process: **– To complete your application, you must submit the following materials.**

1. **Complete the Junior Volunteer Application form** – Make sure all contact information is current and accurate.

- **Reference Form** – Provide three letters of recommendation or have three reference forms completed from professionals: i.e., guidance counselor, teacher, professor, pastor, coach, or supervisor/employer. **(Only submit 3)**
- **Essay** – Submit a one-page essay in MLA format, outlining the reasons why you would like to volunteer at McLeod.
- **Immunization records –** Provide a copy of your recent immunization records from your physician or DHEC
- **Report Card** – Submit a copy of your latest report card, demonstrating an overall "B" average.
- **Marketing Release Form** – Complete and sign the Marketing release form (both student and parent/guardian. (For authorization to capture and use your photo).
- **ID Badge Form –** Fill out the top portion of the ID Badge form and return it. You will be contacted later to have your picture taken, which we recommend scheduling on the same day as your TB screening.
- **Health Clearance –** Complete and sign the Tuberculin (TB) Test release form. If accepted into the program, you will receive a tuberculin screening at no cost. The screening is a blood test that will be administered at McLeod Occupational Health Services on a designated date. Failure to complete the test will render you ineligible to participate in our volunteer program.

- The enclosed preference sheet indicates your preferred volunteer placement.
  - Please note that assignment to your first preference is not guaranteed.
  - Positions are filled based on availability in participating departments.
  - You may choose to volunteer one 8- hour or two 4-hour shifts per week.
  - Certification of hours will only be provided to students who complete 50 hours or more at the end of the 8-week period.
  - Please be aware that some junior volunteering assignments will be located outside the main hospital or Pavilion, requiring walking, crossing streets or traveling to Enterprise Drive and/or McLeod Health & Fitness Center.

It is very important that you carefully consider the amount of time you can dedicate during the summer. Reflect on the time required for family vacations, extracurricular activities (band, sports), employment, and other commitments or obligations. Please review the attached information and ensure you can meet the requirements before completing your application.

There is limited availability 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

CHECKLIST: Verify that all components are complete prior to submitting your application packet.

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

All this information must be submitted to the Volunteer Services office by Friday, APRIL 10, 2026.

We are located at:
McLeod Health
555 E. Cheves Street
Florence, SC 29506
Main Tower (Building 2) on the 2nd floor

Mail to:
MRMC Volunteer Services
PO Box 100551
Florence, SC 29502-0551
Fax: 843-777-9757

*If you choose to email your application, please scan and send documents as a PDF attachment to:
teresa.timmons@mcleodhealth.org
INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

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Deadline: April 10, 2026

JUNIOR VOLUNTEER APPLICATION

Start date: June 1, 2026 – July 24, 2026

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

First Name: _____ Middle Name: _____ Last Name: _____

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

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____- _____- _____ Cell Phone: _____- _____- _____

Email address_____

T-Shirt Size: XS S M L XL 2XL 3XL 4XL (Please circle)

PARENT OR GUARDIAN

1. Father's Name _____ Cell Phone: _____- _____- _____

Employer: _____ Work Phone: _____- _____- _____

Email address_____

2. Mother's Name_____ Cell Phone: _____- _____- _____

Employer: _____ Work Phone: _____- _____- _____

Email address_____

In case of emergency, contact:

Name _____ Relationship _____ Cell Phone**:** _____- _____- _____

SCHOOL INFORMATION:

Name of school you attend: _____ Grade Entering: _____

List any school, church and/or 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 B average or above 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

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 special work assignment? Yes ____ No ____

If yes, please provide details _____

_____

_____

PLANNED ABSENCES OR SCHEDULED VACATION DATES:

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, 2/24, 2/25, 1/26

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 prefer. However, we must have an available opening in that department. Please note that all volunteers must complete a **minimum of 50 hours** to be eligible for return during the school year or next summer.

Can you commit to the entire 8-week program with a minimum of 50 hours for the summer?
Yes ____ No ____

I am available to volunteer on the following days: (circle)
Monday Tuesday Wednesday Thursday Friday

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.

Full days: 8:30 a.m. – 4:30 p.m.

Please check the area that interests you. Volunteer placement depends upon the needs and requests of hospital departments. (See attached sheet)

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)
_____ Cardiac Rehab, Physical or Pediatric Rehab (located at the Health and Fitness Center)

Please list <u>any</u> area in which you are interested in: _____
_____

_____

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Junior Volunteer Opportunities May Include:

Administrative & Office Support

- Accounting
- Admitting / Registration
- Clerical & Computer Support (Filing)
- Front Desk Assistance
- Home Health
- Human Resources
- Information Desk
- Marketing
- Medical Records
- Procurement
- Reception
- Risk & Quality Management
- Service Excellence

Clinical & Patient Support (Limited Hands-On)

- Clinical Units (Nursing Floors)
- Cardiac Rehabilitation (Health & Fitness Center)
- Children's Hospital
- Day Hospital
- Emergency Department
- Oncology Floor
- Physical or Occupational Therapy (Health & Fitness Center)
- Respiratory Therapy
- Radiology
- Patient Transport
- Surgical Waiting Area

Facilities, Operations & Support Services

- Bio-Med
- Engineering (Maintenance)
- Environmental Services (EVS)
- Laundry
- Nutrition Services
- Culinary Arts (Cafeteria)

Childcare, Retail & Special Programs

- Child Development Center
- Gift Shop
- McLeod Activity Center for Kids (MACK) @ Fitness Center
- Musicians (playing an instrument or piano)
- Volunteer Ambassador / Wayfinding (greeting visitors and escorting them to destinations)

And more…

We do our best to assign you to your preferred location; however, due to high demand in certain departments, this may not always be possible.

JV Application
Created: 2/22
Revised: 1/26
Reviewed: 1/26

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Reference Form

Applicant's Name: _____

Applicant's Email Address: _____

Reference Name: _____

Reference Email: _____

Reference Phone Number: _____

We appreciate your willingness to provide a professional reference for the applicant to our McLeod Junior volunteer program. Your candid evaluation of their maturity, skills, and abilities is invaluable to us. Thank you for dedicating the time to complete this form. Once finished, kindly place it in an envelope and return it to the applicant or scan and email it to teresa.timmons@mcleodhealth.org. We are grateful for your prompt response, as we cannot initiate the consideration process until all references are received. If you have any inquiries or prefer to discuss the applicant over the phone, you may contact Volunteer Services at 843-777-2082 or via fax 843-777-9757. Thank you.

1. How long have you known the applicant? _____

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

3. Do you believe the applicant will be a valuable addition to our volunteer department? _____

4. Please describe the skills or characteristics the applicant possesses that will be beneficial to our program.

_____

_____

_____

_____

Please provide any additional comments that you believe would be helpful with our evaluation process:

_____

_____

_____

Is the applicant able to work collaboratively as part of a team? ☐ Yes ☐ No

Is the applicant reliable? ☐ Yes ☐ No

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

Reference Signature: _____ Date: _____

Deadline: April 10, 2026

Created: 2/23
Revised: 2/24
Reviewed: 2/25, 1/26

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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 McLeod Volunteer Services (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

(THIS IS REQUIRED)

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

(RETURN THIS FORM WITH PACKET)

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 TB blood test must be completed.** 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 required to undergo a chest x-ray in Occupational Health Services, along with any follow-up measures that is medically indicated by the x-ray results, at no cost, if required. Upon completion of the TB assessment, Occupational Health will issue a medical clearance, allowing my son/daughter to begin volunteer service.

Applicant Signature: _____

Name of Parent/Guardian: _____

Parent/Guardian Signature: _____

Date: _____

*****Please do NOT get your TB test until we notify you. *****

JV Application
Revised: 1/17, 6/18, 2/19,1/20, 2/21, 2/22, 2/23, 2/24, 2/25, 1/26

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 #: 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)