

McLeod Health Cheraw

Thank you for your interest in the McLeod Health Cheraw 2026 **Jr. Summer Volunteer Program**. The program is open to high school students ages 15-18 years old and will run from June 4 to July 24. 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 15, 2026.
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 15, 2026:
 - 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) 320-3354 or email angela.berdeau@mcleodhealth.org.

With our mission in mind,

Angela M. Berdeau
Executive Assistant/Volunteer Coordinator

Enclosures: Jr. Volunteer Application and Tuberculin Consent Form

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 Wednesday, June 3 from 1:30 p.m. to 2:30 p.m. or Thursday, June 4 from 5:30 p.m. to 6:30 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 Friday, May 15, 2026.

- Turn in at the hospital front desk with attention to Angela Berdeau or scan it as a pdf and email it to angela.berdeau@mcleodhealth.org

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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 _____

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 _____

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)



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 would be available to be scheduled on the following days: (circle)

Mon Tues Wed Thurs

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.

Number of days scheduled will depend on number of volunteers.

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.

JV Application

Revised: 6/18, 11/19, 01/20, 2/23; 3/24 Reviewed: 2/19, 02/20, 2/21, 2/22, 2/23; 3/24; 3/25; 3/26

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.

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

JV Application: Created: 2/22; Revised: 03/26

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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 angela.berdeau@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 843-320-3354.

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: _____

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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
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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
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x _____	x _____	_____
Print Volunteer Name	Volunteer Signature	Date

x _____	x _____	_____
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-DII 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: ___ / ___ / ___ Stop Date: ___ / ___ / ___ Approved Credentials: _____

Print Name Manager/Supervisor: _____

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)