

# McLeod

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## 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 9, 2026
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 a letter of recommendation 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.
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. All information must be submitted no later than **Friday, May 8, 2026 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

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**YOUR CHECKLIST**

- Completed and signed Application
- Recommendation letter
- Signed tuberculin screening form
- One-page essay
- Copy of immunization record
  
- Copy of report card

**All information must be in our office no later than May 8, 2026.**

# McLeod

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## Medical Center Dillon

### 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

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List honors and awards you have received at your school or church

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Have you ever volunteered before? Yes \_\_\_ No \_\_\_ If yes, where and what did you do?

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Are you interested in a health-related career? \_\_\_\_\_ If so, what are your interests?

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#### 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.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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, June 5, 2026, between 8 a.m. and 11 a.m. 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.

**Junior Volunteer's Name** \_\_\_\_\_  
(Please print)

**Date of Birth:** \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Pam Strickland  
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
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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): 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

## 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 Department #: \_\_\_\_\_  
 MMC-Darl  MMC-Dil  MH&F  FDTN  Home Health

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