

# McLeod Volunteer Services

# Junior Volunteer

## Summer Program

June 1, 2026 - July 24, 2026

**McLeod Volunteer Services is currently taking applications for the Summer Junior Volunteer Program at McLeod Regional Medical Center.**

**For more information, contact the Volunteer Services office at 843-777-2082 or 843-777-2234.**

To download an application, please visit:

**<https://www.mcleodvolunteers.org>**

(Limited number due to position availability)

### Criteria:

- Eligibility Age: 13-17 years old
- Complete application
- Overall "B" average
- Commit to the 8 week summer program
- Submit three letters of recommendations
- One page essay on why you would like to volunteer at McLeod
- Recent Immunization record

**Submission Deadline is April 10, 2026**

**For questions and inquiries contact:**

Linda Boone at 843-777-2234

[lboone@mcleodhealth.org](mailto:lboone@mcleodhealth.org)

Teresa Timmons at 843-777-2082

[teresa.timmons@mcleodhealth.org](mailto:teresa.timmons@mcleodhealth.org)

**McLeod Health**

The Choice for Medical Excellence



# McLeod Health

## The Choice for Medical Excellence

Dear Guidance Counselor,

McLeod Regional Medical Center is now accepting applications for our 2026 Summer Junior Volunteer Program. This eight-week program is open to middle and high school students (ages 13–17) and offers teens the chance to gain hands-on experience in a healthcare setting while serving the community. Junior volunteers will work alongside healthcare professionals and assist with meaningful tasks that support patient care and hospital operations.

**Program Details:**

- **Dates:** June 1 – July 24, 2026
- **Length:** 8 weeks
- **Minimum Hours:** 50 hours
- **Application Deadline:** April 10, 2026
- **Orientation:** Mandatory for accepted students (date to be announced)

Volunteering provides students with personal satisfaction while helping them develop responsibility, teamwork, communication, and leadership skills. It is also an excellent opportunity for career exploration and experiential learning for those interested in healthcare or related fields.

Applications are enclosed, and additional copies can be downloaded at:  
<https://www.mcleodhealth.org/services/community-involvement/volunteers/>

Please share this opportunity with students who may be interested. If you or your students have any questions, feel free to contact our office at 843-777-2082 or fax 843-777-9757.

Thank you for your support.

With our mission in mind,



Linda Boone, CDVS  
Director Volunteer Services/Gift Shops  
843-777-2234

Enclosure: flyers, application

# 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.

- o **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](mailto: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 | _____ Signed ID Badge form          |
| _____ One-page essay (MLA format)                                       | _____ Preference sheet completed    |
| _____ Reference Form/Recommendation letter (3)                          | _____ Copy of latest report card    |
| _____ Signed tuberculin screening form                                  | _____ Signed Marketing Release Form |
| _____ Copy of current immunization record                               |                                     |

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 2<sup>nd</sup> 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](mailto:teresa.timmons@mcleodhealth.org)**

**INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED**

# McLeod Health

The Choice for Medical Excellence

## JUNIOR VOLUNTEER APPLICATION

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

**Deadline:**  
**April 10, 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.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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 any area in which you are interested in: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**JV Application**

Revised: 6/18, 11/19, 01/20, 2/23, 2/25

Reviewed: 02/20, 2/21, 2/22, 2/23, 2/24, 2/25, 1/26

# McLeod Health

The Choice for Medical Excellence

## 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...

#### **JV Application**

Created: 2/22

Revised: 1/26

Reviewed: 1/26

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.

# McLeod Health

The Choice for Medical Excellence

## 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](mailto: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**

# McLeod Health

## The Choice for Medical Excellence

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
----------------	---------	------	-------	-----

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> My medical prognosis   | <input type="checkbox"/> Only general one-word condition           | <input type="checkbox"/> My city, county or state |
| <input type="checkbox"/> My age   | <input type="checkbox"/> Date/Time of expected or actual discharge |   |
| <input type="checkbox"/> Information about my specific injuries or medical condition  |  |   |
| <input type="checkbox"/> Information to conduct an interview with me or take a photograph of me for a future McLeod publication                     |  |   |
| <input checked="" type="checkbox"/> Use of my photograph, audio, testimonial, or appearance in filming or in print for publication by McLeod Health |  |   |
| <input checked="" type="checkbox"/> Use of my photograph, audio, testimonial, or appearance in video for Social Media purposes                      |  |   |
| <input type="checkbox"/> 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 _____	X _____	_____
Print Volunteer Name	Volunteer Signature	Date
X _____	X _____	_____
Parent Signature	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**

**McLeod Health**

*The Choice for Medical Excellence.*

**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  1 Hispanic/Latino  2 Not Hispanic/Latino

Race:  1 White  2 Black/African American  3 Asian  4 American Indian/Alaskan Native  5 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 Department #: **18325**  
 MMC-Dart  MMC-Del  MH&F  PDN  Home Health 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  3= 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)