Deadline for application: April 5 – April 18, 2026

Dear Summer Teen Applicant:

Thank you for your interest in the Summer VolunTEEN Program at Methodist Healthcare.   Youth volunteer positions are available at Methodist University, North, South, Germantown, and Olive Branch Hospitals. Applicants must be 16 years old by June 1, of program year.

For your application to be reviewed, it is required that you submit all of the following by the application deadline:

1. The application form.
2. Two references from teachers or counselors.
3. The Parental Consent and Release Form.
4. The Photo/Media Consent Form.
5. A copy of your birth certificate, driver's permit, or passport.
6. Immunization records for proof of MMR (measles, mumps, rubella), and chicken pox.
7. A 200 word essay on why you would like to volunteer, and what interest you have in the medical field.

We'll need to have your application in our office by the deadline. Please submit it through the mail, **scan and email it to Sandra Moore in Volunteers Services**, or by dropping it off at our office (see contact information at bottom of page). Once we receive your completed application with all of the materials above, your application will be reviewed and if selected, you will be contacted for an interview. We will notify you after the interview if you have been selected. **Please note that this is a four-week program, and applicants are expected to complete the full four weeks.** We have limited VolunTEEN positions available. We recommend that you apply early.

A tuberculosis (TB) skin test will be required after you are accepted as a VolunTEEN (or proof of TB skin test, if applicable). The TB skin test will be administered by Methodist Healthcare, and you will receive instructions on where to get the test. **For safety and infection control reasons, you will not be able to attend orientation or volunteer if we do not receive your medical clearance forms prior to orientation.** There are no exceptions to this requirement.

*The mandatory orientation for all VolunTEENs will be held at **Methodist University Hospital** on Monday, June 1, from 8:30 a.m. until 1:30 p.m., in the Center of Excellence in Faith & Health. If you cannot attend orientation, you will not be able to participate in the VolunTEEN Program. After orientation is complete, you will report to your facility/department to volunteer for the next three and a half weeks.*

Summer hours and dates are as follows:

June 1   (Orientation)
Monday
Hours: 8:30 a.m. - 1:30 p.m.
Location: Methodist University Hospital, Center of Excellence in Faith & Health

June 2 – 25 (3.5 weeks at Assigned Facility)
Monday – Thursday (no Friday volunteer dates)
Hours: 8:30 a.m. – 3:30 p.m. (unless other times are agreed upon by the hosting department)

Again, thank you for your interest in our volunteer program. We hope that you will have a positive learning experience this summer. Should you have any further questions, please call (901) 516-7481.

Sincerely,

Volunteer Services Department
Methodist Le Bonheur Healthcare

Methodist Healthcare

Methodist Healthcare
Volunteer Services Department
1265 Union Avenue, Suite E-161
Memphis, TN 38104
901.516.7481 (office)
Sandra.Moore@mlh.org

For office use only – 2026
___ Proof of MMR
___ Proof of Chicken Pox
___ Parental Release Form
___ Birth Certificate/Drivers Permit
___ References (2)
___ Essay
___ TB
___ Media Release
Accepted Yes No

Preferred Name / Nickname: ______________________________

Address: ______________________________
Street City State Zip Code

Phone: ______________ E-mail address: ______________________________

Date of Birth: ______________ Last 4 digits of Social Security #: ______________

Have you been in this program previously? ☐ Yes, Year: ________ ☐ No

If one parent/ legal guardian is employed by Methodist Healthcare, teen must be age 16 by June 1, of program year.

Methodist employee name: ______________________________ Phone: ______________

Emergency Contact Name & Phone: ______________________________

Physician Name & Phone: ______________________________

Volunteer/Work experience: ______________________________

____

What is your area(s) of interest? ______________________________

____

Goals for your volunteering experience: ______________________________

____

Attach to this application proof of your first and second measles-mumps-rubella AND your chicken pox inoculation. A physician's note on letterhead or another source will be adequate. Please also provide a copy of your birth certificate, driver's permit or passport. If accepted to the program, we will provide a mandatory tuberculosis skin test (no cost to you).

I consent to my son/daughter volunteering his/her time at Methodist Le Bonheur Healthcare and give my permission for him/her to participate in this volunteer program. Two references from the teen's teachers are required and must be completed and returned with this application. All volunteers must keep all patient information and hospital business completely confidential at all times.

______________________________ ______________________________
Printed Name of Parent/Guardian *Signature of Parent/Guardian* *Date*

______________________________ ______________________________
Printed Name of Teen *Signature of Teen* *Date*

METHODIST HEALTHCARE
VOLUNTEER SERVICES
SUMMER TEEN PROGRAM

Teacher/Counselor Recommendation for Summer Teens

Student Name: ____ Grade Level: ______________

School Name: ____

School Address: ____

Methodist Healthcare is seeking students for the Summer Teen Program who are responsible, dependable, caring, and possess the ability to provide high-quality service to our patients, guests, and staff. We ask that you carefully consider the criteria when completing this form.

Thank you for taking the time to complete this recommendation form. Please return it to your student to be mailed in with their application.

Please circle the appropriate rating:

School Attendance	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Punctuality	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Conduct	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Dependability	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Follows Instructions	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Accepts Responsibility	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Shows Initiative	*Excellent*	*Good*	*Average*	*Fair*	*Poor*

Scholastic Average ( ) 77-85 ( ) 86-92 ( ) 93-100

Do you recommend this student as an applicant for the Summer Teen Program here at Methodist Healthcare?
( ) Yes ( ) No

Comments: ____

____

Name/Position: ____

Telephone: ________________________________ Best time to call: ______________________

____ ________________________
Signature *Date*

If you have questions, please contact Volunteer Service Office at 901.516.7481

2026

METHODIST HEALTHCARE
VOLUNTEER SERVICES
SUMMER TEEN PROGRAM

Teacher/Counselor Recommendation for Summer Teens

Student Name: ______________________________________ Grade Level: _____________

School Name: ____

School Address: ____

Methodist Healthcare is seeking students for the Summer Teen Program who are responsible, dependable, caring, and possess the ability to provide high-quality service to our patients, guests, and staff. We ask that you carefully consider the criteria when completing this form.

Thank you for taking the time to complete this recommendation form. Please return it to your student to be mailed in with their application.

Please circle the appropriate rating:

School Attendance	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Punctuality	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Conduct	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Dependability	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Follows Instructions	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Accepts Responsibility	*Excellent*	*Good*	*Average*	*Fair*	*Poor*
Shows Initiative	*Excellent*	*Good*	*Average*	*Fair*	*Poor*

Scholastic Average ( ) 77-85 ( ) 86-92 ( ) 93-100

Do you recommend this student as an applicant for the Summer Teen Program here at Methodist Healthcare?
( ) Yes ( ) No

Comments: ____

____

Name/Position: ____

Telephone: _______________________________ Best time to call: _____________________

____ _____________________
Signature *Date*

If you have questions, please contact Volunteer Service Office at 901.516.7481

METHODIST HEALTHCARE
PARENTAL CONSENT AND RELEASE FORM
SUMMER TEEN PROGRAM

Printed Name of Teen: ____

Birth Date of Teen: _____________________________

I, the undersigned parent, or legal guardian of the above referenced teen, hereby authorize and consent to teen's participation in the Summer Teen Program.

I understand that Applicant's participation in the program may include tours of hospital departments.

I acknowledge that some teens will be placed in patient care areas and I understand the potential risks regarding communicable diseases and infections in a hospital setting.

If accepted into the summer teen program, I understand that attendance at and completion of hospital orientation is required.

I understand that the Volunteer Services office will make every attempt to notify me in the event that my child is sent to Associate Health or the Emergency Department if they become ill or injured while volunteering.

I further release and hold harmless Methodist Healthcare-Memphis Hospitals, and its affiliated corporations, for and from any personal injury or property damage which teen may incur as a result of teen's participation in the Program.

This agreement shall be governed by the laws of the state of Tennessee and any legal action relating to or arising out of this Agreement shall be commended exclusively in Shelby County, Tennessee.

Printed Name of Parent/Guardian: ____

Signature: ____

Relationship to Applicant: ____

Date: __________________

This form should be completed by the teen's parent and/or guardian.

CONSENT FORM

for Photography, Videotaping, Interviewing, and Recording

Methodist Le Bonheur Healthcare Marketing & Communications Department

901-516-0600 • 1211 Union Avenue, Suite 865 • Memphis, TN 38104

I,____, authorize Methodist Healthcare to photograph, videotape, interview or record me for internal and external stories and publish in print or electronically, limited to the following conditions:

____

____

____

____

____

______________________________	____________	____________
Signature of patient or authorized Individual	Date	Time

______________________________	______________________________
Relation, if signed by other than patient	Date of birth
______________________________	______________________________
Address	Phone number

Provide patient with a signed copy. Retain a signed copy on file for six (6) years from the date of this authorization. This consent form will expire 20 years from the initial date signed. Form must be filled out completely. If a patient authorization revocation is received, attach revocation with this form and file together.

The photograph, video, etc. taken by Methodist Healthcare involves no direct or indirect payment to Methodist Healthcare from the party receiving the authorized photograph.

Methodist Healthcare is hereby released from all legal liability that may arise from the release of the photograph or recording requested. Should the recorded material be redistributed by the publication receiving it, the patient's recording may no longer be protected by federal HIPAA Privacy Regulations 45 C.F.R Part 164. Methodist Healthcare will place no conditions on treatment, payment, enrollment or eligibility for benefits based on whether or not the authorization is signed except for:

- Research-related treatments that may be conditional on an authorization; or
- When healthcare is solely provided for the purpose of creating information to be disclosed to a third party and the patient authorization is required; or
- When a health plan places conditions on enrollment or benefits on the provision that the health plan requires authorization prior to the individual's enrollment in the health plan for underwriting or risk rating determinations, and the authorization is not for a use or disclosure of psychotherapy notes.

I understand that I may revoke this authorization with a written request to the Methodist Healthcare Marketing & Communications Department , 1211 Union Avenue, Suite 865, Memphis, TN 38104 at any time except:

- To the extent that Methodist Healthcare has taken action relying on this authorization; or
- If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.