For Office Use

Received: _____

☐ Vaccinations

☐ Letter of Rec

☐ TB test

☐

MEMORIAL HOSPITAL
MINI MEDICAL UNIVERSITY

Mini Medical University for Teens (MMU) Application 2026

Name: _____ Preferred Name:_____ Pronouns:_____

Home Address: _____
Street Address City, State Zip Code

Preferred Phone _____ ☐mobile ☐home Unisex T-shirt Size: _____

Email: _____ Parent/Guardian Email: _____

Emergency Contact:_____ Relationship: _____

Emergency Phone:_____ Alt. Phone: _____

Name of School:_____ Current Grade:_____ Graduation Year: _____

Medical Field Areas of Interest (up to 3): _____

Session Information:

Each session is scheduled Monday-Friday from approximately 8 a.m. to 4 p.m. | Cost: $400.00

Please number your session date choices from 1-3 (1 being your preferred session; NA if not available)

101 A: June 15-19 _____ | **101 B**: June 22-26 _____ | **101 C**: July 13-17 _____

Dietary Allergies/Restrictions: _____ Accessibility Accommodations? ☐ YES ☐ NO

What is the highest academic degree held by your legal guardian or parent? _____

Application Requirements

I. **Statement of Interest**: Please submit the application question form. To access the form, scan the QR code or use the following link: https://forms.gle/CeUEP7bdtcxDGSXA9

II. **References**: Please denote two individuals (non-related) who can act as references for your application. Upon receiving your application, Volunteer Services will independently request their responses via email.

Name: _____ Email: _____ Relationship: _____

Name: _____ Email: _____ Relationship: _____

Application requirements continued on next page

III. **Health Records**: A copy of official health records (with name and birth date) that include the following information is required to be considered for Mini Medical University for Teens. Records can be mailed, emailed or faxed to Volunteer Services.

a. 2 dates of MMR vaccination
b. 2 dates of Varicella vaccination or mm/yyyy of chicken pox
c. Tdap vaccination
d. Negative TB titer (recommended) or Mantoux skin tests*
    i. TB titer (recommended): QuantiFERON-TB Gold test, dated within 12 month of MMU session dates
    ii. Mantoux tuberculin skin tests: You must complete **two separate** Mantoux skin tests. One must be dated within 12 months of MMU session dates and one within 30 days of MMU session dates. Tests must be at least on week apart from each other. Each result must include millimeters of measurement and two dates (test administered and read)

TB tests may have fees associated with them and are not required to be offered a spot in a session. However, a negative result is a requirement for **participation in MMU. We must receive a compliant TB record **at least 3 weeks before the session start date** or acceptance offers may be rescinded.*

IV. *(Optional)* **Need-Based Scholarship Application**: Through the generosity of the Beacon Health Foundation, we are excited to offer several scholarships to cover the $400 cost of attending Mini Medical University for Teens 2026. Scholarships are awarded to accepted applicants as demonstrated by need. Applicants interested in being considered for financial aid should complete prompts *a* through *c.* Only those interested in being considered for financial aid should complete this section.

a. Are you eligible for the Federal *Free* Lunch Program? YES NO
b. If not, are you eligible for the Federal *Reduced Price* Lunch Program? YES NO
c. Are you a child in a single-parent household? YES NO

V. **Signature**: I certify that the information above is correct to the best of my knowledge, and that I will abide by Memorial Hospital's Volunteer Standards of Conduct and Performance Essentials.

_____ _____
Applicant Signature *Date*

_____ _____
Parent or Guardian Signature, if under 18 years *Date*

MEMORIAL HOSPITAL
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MMU Participation Essentials 2026

Mutual Respect:
I commit to consistently practice the following respectful behaviors:

- ❖ I will always approach the person I have an issue with assuming good intent.
- ❖ I will always seek to resolve problems in a collaborative and mutually respectful manner.
- ❖ I will be mindful of individual differences, and cultural and ethnic diversity.
- ❖ I will not participate in or listen to non-collaborative conversations regarding other members of the team. I will stop the conversation and direct the person(s) involved by saying "In respect of _____, I prefer you speak directly to them.
- ❖ I will receive feedback in a collaborative manner.
- ❖ If I am unable to resolve an issue with my co-campers on my own, I have the responsibility and will seek staff's assistance to help me facilitate a positive resolution.

Standards of Conduct:

- ❖ I understand and will abide by the *Volunteer Standards of Conduct*.

Health & Illness Guidelines:

- ❖ I will not report for MMU with any of the following symptoms and will not return until I have been symptom-free for 24 hours.

- Open/unhealed cold sores (or can mask when in clinical spaces)
- Temperature of 100 degrees or greater
- Gastroenteritis
- Vomiting/diarrhea of unknown origin
- Shingles, Herpes Zoster
- Chickenpox, Varicella zoster (or exposure to)
- All rashes when in patient care or food areas
- Pink eye (conjunctivitis) requires eye drops for a 24-hour period
- Scabies (or exposure to)
- Lice (or exposure to)
- Tuberculosis (or exposure to)
- Draining lesions/wounds
- Uncontrolled coughing or other respiratory symptomology

_____	_____	_____
Applicant Name	*Applicant Signature*	*Date*
_____	_____	_____
Parent or Legal Guardian Name, if under 18 years	*Parent or Legal Guardian Signature if under 18 years*	*Date*

MEMORIAL HOSPITAL
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Non-Employee Confidentiality and Non-Disclosure Agreement

Specific for Volunteer and Student Use Only

(Please Print)
First Name: _____

Middle Initial: _____

Last Name: _____

Home Phone #: ( )_____

BHS Department: _____

School/Organization Affiliation (Optional): _____

Email: _____

Mobile Phone #: ( ) _____

Security and **confidentiality** are matters of concern for all persons who have access to information **from Beacon Health System (Beacon)**. Each person accessing any Beacon information, **including, but not limited to, patient, provider, administrative, employee and financial information,** holds a position of **trust** relative to this information and must recognize the **responsibilities** entrusted in preserving the **security** and **confidentiality** of this information.

As a condition to receiving access to information, I,_____, agree to comply with the following terms:
(Print Name)

1. I will not at any time **during or after** my affiliation with Beacon disclose patient, business, financial, or employeeinformation to which I have access in any form (i.e. electronic media, paper, microfilm, verbal, etc.) without prior written consent of Beacon or unless required by law.

2. I will not **access or request information** on myself, patients (Protected Health Information), or any other confidential information including Beacon's financial or personnel information, unless the access to this information is required by my job.

3. If I am assigned a computer login, I understand it is the equivalent to my **LEGAL SIGNATURE**, and I will not share or disclose my login information, **including user names or passwords**, to anyone. In addition, I will not attempt to use another person's login and password. I am **responsible and accountable** for all entries made and all information accessed under my login.

    a. If I have reason to believe that another person knows my computer login, I will **immediately** follow the approved procedure for changing my password. I will also immediately notify the Information Security Team at InformationSecurity@beaconhealthsystem.org and/or mydirect supervisor.

4. I will secure the computer when not in use to prevent unauthorized access.

5. I will respect the confidentiality of any reports and handle, store, and dispose of these reports according to Beacon policies and procedures. I will also respect the confidentiality of information stored on the computer, including any portable computers or devices I may work with.

I acknowledge my responsibility as an affiliate of Beacon. I understand there are disciplinary procedures in place for handling breach of confidentiality. I have read and understand the above Confidentiality and Non-Disclosure Agreement. I understand that my use of Beacon information will be monitored to ensure compliance with this agreement. I further understand that if I violate any of the above terms, I may be subject to disciplinary action, including civil or criminal action being taken against me, loss of privileges to access information, termination of contract or any other legal remedy available to Beacon. I accept my obligation to maintain the confidentiality of patient and provider information and agree to abide by the terms of the Agreement.

Participant Signature:_____ Date: _____

(For Participants under 18 years of age): Parent/Guardian Name: _____
(Print Name)

Parent/Guardian Signature: _____ Date: _____

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Social Media Policy

When using social media:

- Be clear that your posts reflect your personal opinion and not those of Beacon Health System.
- Know that "friending" patients on social media is discouraged.
- Know that only the Beacon Marketing and Corporate Communications departments can create Beacon-branded social media pages, websites, blogs, etc.
- Never post pictures of patients.
- Never disclose confidential information about patients and clients, business arrangements and strategic business plans or other proprietary information

I acknowledge my responsibility as a Volunteer of Memorial and Beacon Health System to uphold the Social Media Policy. I understand there are disciplinary procedures in place for handling breach of confidentiality. I have read and understand the above Social Media Policy. I accept my obligation to maintain the confidentiality of patient and provider information and agree to abide by the terms of the policy.

Applicant Name	*Applicant Signature*	*Date*
Parent or Legal Guardian Name, if under 18 years	*Parent or Legal Guardian Signature if under 18 years*	*Date*

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Patient Identification

CONSENT TO PHOTOGRAPHY OR INTERVIEW

I hereby authorize representatives of Beacon Health System to participate in the following activities, as indicated by checkmark:

☐ Photograph, film or videotape me as a current or former patient, or a participant in a Beacon Health System program, for use by Beacon in all or any of the following: publications, audio-visual presentations, fundraising materials or for any other print or web use, including social media or broadcast media.

☐ Contact/Interview me as a current or former patient, or a participant in a Beacon Health System program, for use by Beacon in all or any of the following: publications, audio-visual presentations, fundraising materials or for print, web or broadcast media.

The purpose or use of the photo, film, videotape or interview is:

Website, promotional materials, rosters, and marketing campaigns

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I understand that I may refuse to sign this Authorization and that Beacon Health System will not condition treatment, payment, enrollment in the health plan or eligibility for benefits on the provision of this Authorization.

This authorization is valid until revoked by the patient or an authorized representative. I understand that I have the right to revoke this authorization, except if Beacon has taken action in reliance upon it. My revocation must be delivered, in writing, to *Beacon Marketing, 3245 Health Drive, Granger, IN 46530*.

I understand that images or information disclosed under this Authorization may be disclosed by the recipient and the information will no longer be protected by the privacy law.

Signature of Patient	Date	Time
Signature of Parent or Legal Guardian	Date	Time
Witness	Date	Time

Please print

Patient Name_____ Parent/Guardian Name_____

Mailing Address_____

Phone_____Email_____

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Mini Medical University FAQ's Page

Do I get into my 1st choice of MMU sessions if I am accepted?
We try to accommodate preferences and scheduling as best as possible, but cannot guarantee choice of sessions. Students benefit most if they attend all 5 days, and we encourage you to only rank weeks that students can attend the complete programming.

My child is very interested in healthcare, but does not meet the age/school year recommendations for MMU. Do you accept younger or older applicants?
We will still consider younger high school students, but do not anticipate letting in older applicants at this time. MMU is targeted to high school students who would not be eligible to complete the regular New Volunteer Orientation or participate in the Clinical Observation program..

Once I have been accepted to the program, where can I get a tuberculosis (TB) test?
You have a number of options, as we accept both QuantiFERON-TB Gold tests (recommended) and Mantoux tuberculin skin tests.

If you choose the QuantiFERON-TB Gold test, it must be completed within 12 months of your MMU session dates.

If you choose the Mantoux tuberculin skin test, we require **two separate rounds** of testing, one completed within 30 days of your MMU session dates and one completed within 12 months of your MMU session dates.

Depending on your insurance, it may be cost effective to have testing done by your primary care physician. You can also contact the St. Joseph County Health Department or a 'minute clinic' to schedule your TB tests at their site for a small fee. It is a Mantoux method test, which requires returning to the same office to have it read 48 hours later. Again, you will need **two separate rounds** of the Mantoux test.

Can you guarantee my listed 'medical areas of interest' will be on the program schedule?
To ensure we can get onto providers' calendars, we begin scheduling activities well before applicants are accepted into the program, and cannot guarantee your specific area of interest will be included. To give you an idea of what might be scheduled, we focus on fields that often occur in-hospital, rather than outpatient settings. Your areas of interest are really helpful, though—we like to accommodate if we have flexibility and also use this data to make long-range program improvements.

What should I expect when applying for the $400 scholarship?
Applicants who complete Part IV of the application will be considered for the scholarships. Award recipients will be asked to provide a few short responses after their MMU session to share about their experience in the program.

If our summer plans change, can we receive a refund?
A full refund will be offered to students up until the first day of their session. Uncashed checks will be destroyed and cashed check refunds will be processed by the Accounting department and mailed to the address on the MMU application packet. Credit card payments will be credited back to the payment card. Refunds will not be given to students who begin, but do not finish the week of programming, or who are a 'no call/no show' on the first day of the scheduled MMU Session.

Can you remind me of the important dates?

Friday, April 3, 2026:	Application step 1 review begins. **To be considered for MMU 2026, you must submit your application materials** (aside from TB results) **by this date.**
Friday, April 10, 2026:	Step 1 decisions sent. A select number of applicants will be invited to complete step 2 of the application process.
Tuesday, April 28, 2026:	Application step 2 due.
Friday, May 1, 2026:	MMU 2026 acceptances sent via email.
Tuesday, May 26, 2026:	Negative TB records due for Session A participants.
Tuesday, June 2, 2026:	Negative TB records due for Session B participants.
Tuesday, June 23, 2026:	Negative TB records due for Session C participants.

If you have any questions about Mini Medical University or any of the information above, please do not hesitate to reach out to our office. Thanks again for your interest!

Kara Strang, MPA
Director of Operations

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