MEDICAL CITY MCKINNEY JUNIOR VOLUNTEER PROGRAM 2026

LETTER OF RECOMMENDATION

NAME OF APPLICANT _____

NAME OF INDIVIDUAL COMPLETING RECOMMENDATION _____

RELATIONSHIP TO APPLICANT _____

HOW LONG HAVE YOU KNOWN APPLICANT? _____

You have been asked to provide a letter of recommendation for the above mentioned applicant. Please provide your input as to why you believe this applicant would be appropriate as a teen volunteer at Medical City McKinney. Must be received by MCM no later than 4:00pm on Monday April 13th.

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Use back of sheet, if needed.