A picture containing logo

Description automatically generatedUNIVERSITY OF VIRGINIA HEALTH SYSTEM, MEDICAL CENTER

**PTO LEAVE DONATION FORM**

Donor’s Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_

Employee ID# \_\_\_\_\_\_\_\_\_\_\_\_\_ Department/Unit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My identity \_\_\_\_\_shall be revealed \_\_\_\_\_shall not be revealed to potential recipient.

I wish to donate \_\_\_\_\_ hours of PTO to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Recipient’s Name

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| --- |
| **DONOR’S CERTIFICATION:** I understand and agree to the following provisions:   * Donations to a recipient shall be made in four (4) or eight (8) hour increments with a minimum donation of eight (8) hours. * I can reclaim my donation only if my donation form has not yet been processed. * I must have a minimum balance of 40 hours remaining in my PTO account after donation.   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Donor’s Signature Date** |

Send completed form to Human Resources Solution Center, **Box 400127 or FAX 924-4042**

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| --- |
| HR Office Use Only Date and time donation form received: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hours of PTO transferred: \_\_\_\_\_\_\_\_ Date PTO transferred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Donated PTO not eligible for transfer: \_\_\_\_\_\_\_\_\_hours Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Human Resources Representative’s Signature Date** |

Revised 1.15.21