UNIVERSITY 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 OnlyDate 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