UNIVERSITY OF VIRGINIA HEALTH SYSTEM, MEDICAL CENTER
PTO LEAVE DONATION REQUEST FORM

Last Name _____ First Name _____ MI_____

Employee ID#_____ Department/Unit_____

Home Address_____

Home Phone _____ Work Phone _____

Employment Status: Full-time_____Part-time_____

Reason: (circle one) Health condition for: self family member (relationship to _____)

My identity _____shall be revealed _____shall not be revealed to potential donors.

EMPLOYEE'S CERTIFICATION: I understand and agree to the following provisions:

- I must be a regular full-time or part-time employee scheduled to work at least 20 hrs./week.
- I must exhaust all available accrued leave prior to using donated leave.
- I have received approval for FMLA or Medical Leave for myself, or FMLA or Personal Leave to care for my immediate family member with a serious health condition. **Leave is approved through Unum or UVA HR.**
- I will not be required to reimburse leave hours donated to me unless one of the following situations occurs:
  - ◊ Compensation is received from another source for the same period of time I received donated PTO leave hours, such as when moneys are received from donated PTO leave hours and subsequently workers' compensation benefits are received retroactively for that same period of time; or
  - ◊ Employee Health determines that abuse has occurred. If abuse has occurred, I may be required to repay up to all donated leave, and/or may be subject to disciplinary action in accordance with the Employee Rights and Responsibilities Policy.

_____ _____
Employee's Signature **Date**

SUPERVISOR'S APPROVAL: I am aware of this employee's request for absence beginning _____ and ending _____ that will result in the employee exhausting all available accrued leave balances.

_____ _____
Supervisor's Signature **Date**

_____ _____
Supervisor's Printed Name **Supervisor's Phone No.**

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

Human Resources use only
Maximum hours of donation approved _____. Authorized by _____ on _____.
(Initials) (Date)

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