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

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**

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