

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

DONATION OF PAID TIME OFF FORM

Recipient Name (please print)

Instructions: The Donor **must** maintain a PTO balance of at least two weeks (based upon budgeted hours.) for their own use at all times.

Donor Name (please print)

Number of hours to be donated:
(Minimum of 4 hours; Maximum of 80 hours)

I have reviewed the Atlantic General Hospital/Health System Human Resources policy H-12 "Donation of Paid Time Off".

Donor Signature: _____ Date: _____

Manager Signature: _____ Date: _____

FOR HUMAN RESOURCES TO COMPLETE:

Date Request Received: Donor PTO Balance:

Approved ☐ Denied ☐ Reason for denial: _____

Recipient Hours Needed: Pay Date:

Deducted from Donor: Pay Date:

Human Resources Review: _____ Date: _____

Copy to Payroll ☐

Copy to Donor ☐

Personnel File ☐