PTO DONATION FORM

SOUTH GEORGIA MEDICAL CENTER

Valdosta, Georgia

I request that the value of _____PTO hours be transferred to the below named recipient's PTO accrual bank. I certify that after this donation, I have a minimum balance of eighty (80) hours in my PTO accrual bank.

Donor's Name: _____

Donor's Employee #: _____

DONOR'S SIGNATURE: _____ DATE SUBMITTED: _____

DONOR'S MANAGER'S SIGNATURE: _____

Recipient's Name: _____

Recipient's Employee #: _____

I, attest, that I have verified that the above recipient is benefit eligible, completed his/her introductory period and is not eligible for disability pay. Further, the recipient has exhausted ALL of his/her PTO, BPTO, Sick Leave, and Attendance Bonus and I approve this donation.

RECIPIENT'S MANAGER'S SIGNATURE: _____

PERSONNEL USE ONLY

DONOR INFORMATION:

Number of Hours:	Rate of Pay:	Total in $:

RECIPIENT INFORMATION:

Number of Hours:	Rate of Pay:	Total in $:

Recipient's Address:_____

INSTRUCTIONS TO ACCOUNTING:

Credit _____ hours of PTO to the above named recipient's PTO accrual bank.

Debit _____ hours of PTO from the above named donor's PTO accrual bank.

_____ _____

Approved by: Personnel Assistant/Support for Director of Human Resources **Date**

Rev. 01/14/08