SCOTTSDALE
HEALTHCARE

PTO DONATION FORM

I hereby voluntarily request to transfer _____ hours of PTO (minimum of 4 hours) directly to the PTO account of:

_____

Staff Member Name **(Print)**

Nature of Emergency: **Circle One**

A. The staff member experiences a severe medical emergency (e.g., heart attack, car accident, hospitalization, etc.) requiring a prolonged absence from work (minimum of 5 work days away from work) including intermittent absences related to the same illness or condition. **Recipient application required for severe medical emergency.**
B. The staff member is caring for an immediate family member who is experiencing a medical emergency; or
C. The staff member needs extended time off following the death of a family member.

Please Check One:

__ Keep my donation confidential
__ SHC may release my name as a donor to the recipient.

- I understand that I will not be taxed on the PTO hours donated
- PTO donation is received at the recipient's rate of pay.

Donating Staff Member Name:_____

Employee #____ _____Phone # or extension_____

Donating Staff Member Signature:_____Date_____

Fax Completed Form to Employee Benefits at 480-323-4550

For Employee Benefits Use Only

Donor's Total PTO Balance_____Recipient PTO Balance_____Date_____

_____

HR/Employee Benefits Approval Date Sent to Payroll