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| **PLEASE TYPE OR PRINT INFORMATION** |
| **TO BE COMPLETED BY DONOR (All fields are required)** |
| UM ID #:  | Dept./Unit Name: |
| Last Name:  | First Name:  | M.I.:  |
| Cell/Home Phone:  |  Work Phone:  | E-mail Address:  |
| *My signature on this document certifies I understand that:** *It is my responsibility to read the provisions of the UMPNC PTO Donation Program*
* *Donations may NOT be rescinded in part or whole for any reason once submitted*
* *I may NOT donate hours if I am funded by a Sponsored Research Project account*
* *I must have 40 hours (pro-rated by FTE) of PTO left in my bank after donating hours*
 |
| **NUMBER OF PTO HOURS TO BE DONATED**   |
| PREFFERED RECIPIENT (if applicable)  | Last Name: | First Name: |
| Department Name: Supervisor Name: |
| Donor’sSignature:  | Date:  |
| TO BE COMPLETED BY DONOR SUPERVISOR/MANAGER (*All fields are required)* |
| Last Name:  | First Name:  |
| E-Mail Address:  | Work Phone:  |
| Donor’s Department ID: |
| By signing this form, I attest the donor meets criteria to donate PTO in accordance with the UMPNC PTO Donation Program Article 29 Section I Para 334 |
| Supervisor’sSignature:  | Date:  |
| MICHIGAN MEDICINE HR-PAYROLL OFFICE USE ONLY:Reviewed by Name: Work Phone: Email Address: | Date Request Received: Date Reviewed: |
| I certify the request meets eligibility requirements of the UMPNC PTO Donation Program: Yes [ ]  No [ ] Comments: |
| Michigan Medicine HR-Payroll Representative’s Signature: Date: |
| FAX COMPLETED FORM TO MICHIGAN MEDICINE HR-PAYROLL: 734.615.5822 ATTN: Angie Galvin*The UMPNC PTO Donation Program Committee will send notification of application status to the applicant within seven business days.* |