APPLICATION FOR SHARED PTO LEAVE

Human Resources

Employee Name: ___________________________ ID: ____________
Department: ___________________________ Department Phone: ____________
Supervisor: ___________________________________________________________

The intent of this policy is to allow one staff employee (the “Donor”) to
donate PTO leave to assist another staff employee (the “Recipient”) when the
Recipient or an immediate family member of the Recipient experiences a
prolonged medical condition resulting in the Recipient being placed on qualifying
medical leave. Exceptions may be made in instances of an unforeseen life-
threatening incident or when the employee experiences a non-medical related
crisis.

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

Estimated length of absence from work: ___________________________
Current PTO Balance: ___________________________________________
    *(Exempt employees must attach a copy of your PTO leave record)*

Brief description of the medical condition requiring a prolonged
absence (at least 5 workdays):
________________________________________________________
________________________________________________________
________________________________________________________

Note: Medical Certification and FML request *(if applicable)* must accompany this
application.

**RECIPIENT STATEMENT OF UNDERSTANDING**

I understand that compensation received under the Voluntary Shared PTO Leave
Program is considered taxable income.

*I understand that the receipt of Shared PTO will remain confidential.*

__________________________  ____________________
Signature of Recipient        Date

__________________________  ____________________
Signature of Supervisor       Date