HONORHEALTH™

PTO Donation Recipient Application

Name of Recipient:_____Employee ID# _____

Department Name:_____Supervisor: _____

Email address: _____

Work Phone:_____Home/Cell Phone: _____

Beginning date of absence:_____Anticipated date of return: _____

Nature of PTO need (check one):

☐ I am experiencing my own medical (including maternity for the first 6 weeks only), personal or family emergency requiring prolonged absence from work (minimum of 7 calendar days) including intermittent absences related to the same illness or condition.

☐ I am caring for an immediate family member (as defined in Policy HR1311 FMLA) who is experiencing an unexpected medical emergency or other medical condition, requiring prolonged absence from work (minimum of 7 calendar days) including intermittent absences related to the same illness or condition.

☐ I need extended time off following the death of an immediate family member (as defined in Bereavement Leave Policy HR1344).

Please explain the reason for your leave:

_____

_____

_____

I authorize my physician and/or clinical staff to disclose protected health information (PHI) to the Employee Benefits department to be used or disclosed as in relation to the PTO donation referenced above and is being used or disclosed to process this donation application. The authorization shall be in force and in effect until the date that the above referenced medical condition and/or emergency ends.

Staff member signature:_____Date: _____

For Employee Benefits Use Only:

Recipient's ID#_____PTO Balance: _____ Eligible for PTO donation: Yes / No

_____ _____

Benefits Representative Approval Date approved

Submit completed form to Employee Benefits:

Email: ptodonations@honorhealth.com or Fax: 480-882-5802