



995 Worthington Street, Springfield, MA 01109  
 Telephone (413) 734-5376 FAX (413) 737-7949

### MEDICAL LEAVE ASSISTANCE DONATION FORM

<b>Donor's Name</b>	Work Phone (     )
Program/Department	Home Phone (     )

I hereby voluntarily authorize \_\_\_\_\_ hours of PTO be donated to the Medical Leave Assistance Bank for payroll period ending \_\_\_\_\_. (Donations will be processed the last pay period of each month or during a specific period of request for donations)

I further understand that I must retain a balance of 20 hours of PTO and that this donation is voluntary and cannot be revoked.

\_\_\_\_\_

Employee Signature Date

#### SUBMIT COMPLETED FORM TO HUMAN RESOURCES

**FOR HUMAN RESOURCES/PAYROLL USE ONLY:**

Status of Employee PTR # of hours \_\_\_\_\_ or FT # of hours \_\_\_\_\_ Present PTO Balance \_\_\_\_\_

In accordance with the provisions of the Medical Leave Assistance Program the donation request is:

**APPROVED**       **DENIED** (Reason \_\_\_\_\_)

PTO Hours Donated: \_\_\_\_\_ Transfer Processed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
 Director Human Resource or Designee Date

Original: Human Resource

Copy: Payroll

Copy: Employee