# NEW HANOVER REGIONAL MEDICAL CENTER
## Paid Days Off Donation Form

I hereby authorize New Hanover Regional Medical Center to reduce my PDO balance by _____hours (minimum of 4). Donors are recommended to retain a balance of 96 PDO hours.

In order to ensure adequate time to process the donations, completed PDO Donation Forms must be received by Human Resources one (1) week prior to the pay date that the employee wishes to use donated hours.

### RECIPIENT INFORMATION

Please credit the PDO donation to the following employee based on his/her rate of pay and the value of the donated hours.

Recipient's Name _____ Department _____

Employee Number: _____

Reason for donation: (required: check one)

_____ Personal/Family Illness _____ Leave of Absence _____ Disability
_____ Personal Tragedy _____ Military Leave

**Note**: PDO donation is **only** allowed for one of the above circumstances

### DONOR INFORMATION

I have read and agree to the PDO Donation stipulations contained in the Paid Days Off (PDO) Policy (42.0). I understand these donated PDO hours will no longer be available for my use and that I will be unable to retrieve these hours once donated.

( ) I do not wish for my name to be revealed to the recipient.

Donor's Name _____ Department _____

Employee Number: _____ SS# _____

Department Extension: _____

Donor's Signature _____ Date _____

**PLEASE RETURN COMPLETED FORM TO HUMAN RESOURCES FOR PROCESSING.**

### FOR HUMAN RESOURCES USE ONLY

Donor's PDO Plan: _____ PDO Balance: _____ Pay Rate: _____

Recipient's PDO Plan: _____ PDO Balance: _____ Pay Rate: _____

_____ X _____ / _____ = _____

Hours Donated Donor's Pay Rate Recipient's Pay Rate Hours added to Recipient's Bank

Paycheck Effective: _____

Hours transferred by: _____ Date: _____