<table>
<thead>
<tr>
<th>Kiel Program Policy Summary for Donations</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Kiel Voluntary Vacation/PTO Donation Program allows employees the opportunity to donate accrued vacation or PTO Short Term Bank (STB) hours to fellow employees who have experienced a catastrophic illness or injury and who have exhausted all accrued time.</td>
</tr>
<tr>
<td>• Any eligible employee may donate their accrued vacation or PTO STB in 4-hour increments. Vacation or PTO not yet accrued may not be donated.</td>
</tr>
<tr>
<td>• Donations cannot exceed 50% of the donating employee’s vacation balance (University and Medical Center) or PTO (STB) balance Duke University’s Health System.</td>
</tr>
<tr>
<td>• Donations may be made before or during the recipient’s period of absence. Donations may not be rescinded in part or whole to donors for any reason. Donations made to a recipient who has applied for disability benefits will not be refunded to donors even if the disability benefit is retroactively approved.</td>
</tr>
<tr>
<td>• Donors may specify a recipient or donate to the general leave pool.</td>
</tr>
<tr>
<td>• Donations shall be kept confidential unless the donor has signed a release of confidentiality indicating that their donation can be identified.</td>
</tr>
<tr>
<td>• The maximum amount of donations cannot exceed the period of absence for the approved medical event.</td>
</tr>
<tr>
<td>• Vacation or PTO donations will not be transferred from the donor to the recipient until all of the recipient’s existing vacation/PTO hours have been exhausted.</td>
</tr>
<tr>
<td>• Recipients are only eligible to receive payment for donated hours after the end of their 4 week absence and after their paid time off has been exhausted. Off-cycle checks will not be issued.</td>
</tr>
<tr>
<td>• There can be up to a three-week period before donations are paid on a recipient’s paycheck (please review the Kiel web site for more specific timeframes).</td>
</tr>
</tbody>
</table>
# Kiel Voluntary Vacation/PTO Donation Program Donor Form

**Please Type or Print Information**

## Donor Information (All fields are required)

<table>
<thead>
<tr>
<th>DUKE UNIQUE ID #:</th>
<th></th>
<th>M.I.:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td>First Name:</td>
<td></td>
</tr>
<tr>
<td>Dept/Org Unit Name:</td>
<td>Donor’s Work Phone:</td>
<td>Org Key:</td>
</tr>
<tr>
<td>Duke University</td>
<td>Duke University Health System</td>
<td>Duke Regional Hospital</td>
</tr>
</tbody>
</table>

*My signature on this document certifies that I understand that:*
- It is my responsibility to read the provisions of the Kiel Voluntary Vacation/PTO Donation Program including frequently asked questions.
- Donations may not be rescinded in part or whole for any reason.

**Donations shall be kept confidential unless you authorize for your donation to be disclosed.**

*If Recipient asks, do you desire recipient to know your name and donation?*
- Yes ☐
- No/Keep Confidential ☐

### Number of Leave Hours to Be Donated

<table>
<thead>
<tr>
<th>Vacation:</th>
<th>PTO (Short-term Bank Only):</th>
</tr>
</thead>
<tbody>
<tr>
<td>hours:</td>
<td>hours:</td>
</tr>
</tbody>
</table>

I wish to donate my vacation/short term PTO to: Recipient ☐ as indicated below Leave Pool ☐

## Recipient Name

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient’s Duke Unique ID:</td>
<td>Dept/Org Unit Name:</td>
</tr>
</tbody>
</table>

Donor’s Signature: Date:

## Supervisor and Payroll Representative Information for Donor (All fields are required)

<table>
<thead>
<tr>
<th>Supervisor’s Last Name:</th>
<th>Supervisor’s First Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dept/Org Unit Name:</td>
<td>Supervisor’s Work Phone:</td>
</tr>
</tbody>
</table>

Supervisor’s E-Mail Address:

*I understand the policies of the Kiel Voluntary Vacation/PTO Donation Program and certify that above donation does not exceed 50% of the donating employee’s vacation balance (University and Medical Center) or PTO (STB) balance (Duke University’s Health System).*

Supervisor’s Signature: Date:

<table>
<thead>
<tr>
<th>Payroll Representative Name:</th>
<th>Payroll Rep. Work Phone:</th>
</tr>
</thead>
</table>

Payroll Representative E-Mail Address:

<table>
<thead>
<tr>
<th>Payroll Representative’s Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

*Please send COMPLETED FORM to: Benefits, PO Box 90502, 705 Broad St., Durham, NC 27705 or faxed to 681-8774.*