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GOVERNMENT OF GUAM

LEAVE APPLICATION FORM

NAME (First, Middle, Last)	SOCIAL SECURITY NO.:	DATE OF REQUEST:

TYPE OF LEAVE REQUESTED:

☐ ANNUAL ☐ SICK ☐ LEAVE W/O PAY ☐ COMP-TIME OFF ☐ OTHER (SPECIFY)

LEAVE PERIOD

FROM: (Hour, Month, Day, Year)	TO: (Hour, Month, Day, Year)	TOTAL HOURS REQUESTED:

ADDRESS WHILE ON LEAVE:

APPLICATION FOR PREPAYMENT OF VACATION LEAVE

Minimum requirement is not less than ten (10) consecutive days. It is understood that if I return to duty before the expiration of my prepaid vacation, I shall reimburse the government in the amount equivalent to the unexpired portion of the prepaid leave.

FROM: (Hour, Month, Day, Year)	TO: (Hour, Month, Day, Year)	TOTAL HOURS PREPAID:

SICK LEAVE CERTIFICATION

I certify that the above person was under my professional care or quarantine during the period stated below. From a medical standpoint, his/her condition during this period was such that I considered it inadvisable for him/her to report to work.

FROM: (Month, Day, Year)	TO: (Month, Day, Year)	TOTAL NO. OF DAYS:

REMARKS:

NAME OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL (TYPE OR PRINT)	SIGNATURE OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL

SIGNATURE OF EMPLOYEE:

( ) APPROVED ( ) DISAPPROVED	( ) APPROVED ( ) DISAPPROVED
SIGNATURE OF IMMEDIATE SUPERVISOR	SIGNATURE OF AUTHORIZED OFFICIAL OR APPOINTING AUTHORITY