

GOVERNMENT OF GUAM  
LEAVE APPLICATION FORM

|  |                                     |   |                         |
|--|-------------------------------------|---|-------------------------|
| <b>NAME</b> (First, Middle, Last)  |                                     | <b>SOCIAL SECURITY NO.:</b>                                       | <b>DATE OF REQUEST:</b> |
| <b>TYPE OF LEAVE REQUESTED:</b>  |                                     |   |                         |
| <input type="checkbox"/> ANNUAL <input type="checkbox"/> SICK <input type="checkbox"/> LEAVE W/O PAY <input type="checkbox"/> COMP-TIME OFF <input type="checkbox"/> OTHER (SPECIFY)   |                                     |   |                         |
| <b>LEAVE PERIOD</b>  |                                     |   |                         |
| <b>FROM:</b> (Hour, Month, Day, Year)  | <b>TO:</b> (Hour, Month, Day, Year) | <b>TOTAL HOURS REQUESTED:</b>                                     |                         |
| <b>ADDRESS WHILE ON LEAVE:</b>   |                                     |   |                         |
| <b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>  |                                     |   |                         |
| 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. |                                     |   |                         |
| <b>FROM:</b> (Hour, Month, Day, Year)  | <b>TO:</b> (Hour, Month, Day, Year) | <b>TOTAL HOURS PREPAID:</b>                                       |                         |
| <b>SICK LEAVE CERTIFICATION</b>  |                                     |   |                         |
| 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.            |                                     |   |                         |
| <b>FROM:</b> (Month, Day, Year)  | <b>TO:</b> (Month, Day, Year)       | <b>TOTAL NO. OF DAYS:</b>   |                         |
| <b>REMARKS:</b>  |                                     |   |                         |
| <b>NAME OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL</b> (TYPE OR PRINT)  |                                     | <b>SIGNATURE OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL</b>        |                         |
| <b>SIGNATURE OF EMPLOYEE:</b>  |                                     |   |                         |
| ( ) APPROVED                      ( ) DISAPPROVED  |                                     | ( ) APPROVED                      ( ) DISAPPROVED                 |                         |
| _____<br>SIGNATURE OF IMMEDIATE SUPERVISOR   |                                     | _____<br>SIGNATURE OF AUTHORIZED OFFICIAL OR APPOINTING AUTHORITY |                         |