

GOVERNMENT OF GUAM  
**LEAVE APPLICATION FORM**

<b>NAME</b> (First, Middle, Last)	<b>SOCIAL SECURITY NO.:</b>	<b>DATE OF REQUEST:</b>
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<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"/> TRAINING (LOCAL / OFF-ISLAND)	<input type="checkbox"/> OTHER

<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>
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<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>
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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>
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<b>SICK LEAVE CERTIFICATION</b>
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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>
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<b>REMARKS:</b>
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<b>NAME OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL</b> (TYPE OR PRINT)	<b>SIGNATURE OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL</b>
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<b>SIGNATURE OF EMPLOYEE:</b>
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<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED  <hr style="width: 80%; margin-left: 0;"/> <p style="text-align: center; margin-top: 5px;">SIGNATURE OF IMMEDIATE SUPERVISOR</p>	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED  <hr style="width: 80%; margin-left: 0;"/> <p style="text-align: center; margin-top: 5px;">SIGNATURE OF AUTHORIZED OFFICIAL OR APPOINTING AUTHORITY</p>
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