PRINT Download Clear Form

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 ( ) TRAINING (LOCAL / OFF-ISLAND) ( ) OTHER

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