

GOVERNMENT OF GUAM
LEAVE APPLICATION FORM

NAME (First, Middle, Last)	EMPLOYEE ID NUMBER:	DATE OF REQUEST:
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TYPE OF LEAVE REQUESTED
 ANNUAL SICK LEAVE W/O PAY COMP-TIME OFF TRAINING, LOCAL TRAINING, OFF-ISLAND OTHER

LEAVE PERIOD

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

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

<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED _____ SIGNATURE OF IMMEDIATE SUPERVISOR	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED _____ SIGNATURE OF AUTHORIZED OFFICIAL OR APPOINTING AUTHORITY
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