

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> (    ) ANNUAL        (    ) SICK                    (    ) LEAVE W/O PAY        (    ) COMP-TIME OFF                    (    ) TRAINING (LOCAL / OFF-ISLAND)                    (    ) 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>		

<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  <div style="border-top: 1px solid black; width: 80%; margin: 0 auto; text-align: center;">SIGNATURE OF IMMEDIATE SUPERVISOR</div>	(    ) APPROVED                    (    ) DISAPPROVED  <div style="border-top: 1px solid black; width: 80%; margin: 0 auto; text-align: center;">SIGNATURE OF AUTHORIZED OFFICIAL OR APPOINTING AUTHORITY</div>