GOVERNMENT OF GUAM
LEAVE APPLICATION FORM

Name (First, Middle Last):	Payroll No.:	Date of Request:

Type of Leave Requested:
☐ Annual ☐ Sick ☐ Leave without Pay ☐ Comp-Time Off ☐ Other (Specify)

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 Requested:

SICK LEAVE CERTIFICATION

I certify that the above person was under my professional care or quarantine during the period stated above. 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: (Hour, Month, Day, Year)	To: (Hour, Month, Day, Year)	Total Hours Requested:

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

Revised: 6/6/05 rls