



GUAM MEMORIAL HOSPITAL AUTHORITY

ATURIDÁT ESPETÁT MIMURIÁT GUÁHÑ

850 Governor Carlos Camacho Road, Tamuning, Guam 96913

Operator: (671) 647-2330 or 2552 | Fax: (671) 649-5508



CERTIFICATION PAY DIFFERENTIAL APPLICATION

This application is in alignment with Policy No. A-HR4100. Applications must be accompanied by a copy of the certification, along with additional supporting documents if requested.

EMPLOYEE FULL NAME: <i>Last, First, and M.I.</i>		
POSITION TITLE:		☐ PART-TIME EMPLOYEE ☐ FULL-TIME EMPLOYEE
DIVISION/DEPARTMENT:		
EMPLOYEE ID NO.: <i>Badge No.</i>		
ISSUING ORGANIZATION:		
NAME OF CERTIFICATION:		
DATE EARNED: <i>MM/DD/YYYY</i>		
EXPIRATION DATE: <i>MM/DD/YYYY</i>		
ACKNOWLEDGMENT STATEMENT By signing below, I acknowledge that I have thoroughly read, understood, and agree to comply with the Policy No. A-HR4100 outlined above. Additionally, I confirm that I meet the eligibility requirements outlined in the policy. _____ <i>Employee Signature</i> DATE: _____ <i>MM/DD/YYYY</i>		

APPROVING AUTHORITY

The supervisor's signature verifies that the requested certification aligns with the employee's area of practice.		
IMMEDIATE SUPERVISOR ☐ CONCUR ☐ DO NOT CONCUR	_____ <i>Print Name</i>	_____ <i>Signature</i> DATE _____ <i>MM/DD/YYYY</i>
DIVISION HEAD	_____ <i>Print Name</i>	_____ <i>Signature</i> DATE _____ <i>MM/DD/YYYY</i>
The Human Resources (HR) Department has conducted primary-source verification and affirms that this application meets all established eligibility criteria.		
HR PERSONNEL ☐ CONCUR ☐ DO NOT CONCUR <i>(See attached memorandum)</i>	_____ <i>Print Name</i>	_____ <i>Signature</i> DATE _____ <i>MM/DD/YYYY</i>
HOSPITAL ADMINISTRATOR/CEO ☐ APPROVED ☐ NOT APPROVED		
Joleen M. Aguon, MD _____ <i>Signature</i>		DATE _____ <i>MM/DD/YYYY</i>