LEAVE APPLICATION

FCN 2-0-1 (REV. 12-62)

NAME (First, Middle, Last)	PAYROLL NO.	DATE OF THIS REQUEST

TYPE OF LEAVE REQUESTED

☐ SICK ☐ ANNUAL ☐ MATERNITY ☐ EDUCATIONAL ☐ MILITARY ☐ JURY ☐ OTHERS _____

PAY STATUS		
☐ W/PAY ☐ W/O PAY ☐ COMBINATION	WITHT PAY _____ WITHOUT PAY _____ TOTAL NO. OF HOURS _____	
FROM (Hour, Month, Day, Year)	TO (Hour, Month, Day, Year	CHARGE ALLOTMENT ACCOUNT NO.

ADDRESS WHILE ON LEAVE

APPLICATION FOR PREPAYMENT OF VACATION LEAVE

Minimum requirement is not less than ten (10) consecutive work days. It is understood that if I return to duty before the expiration of my prepaid vacation, shall reimburse the Government in an 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

In compliance with Personnel Rules and Regulations, Government of Guam, if an employee is absent because of illness, injury or quarantine in excess of three consecutive days, or for the day immediately before or after a holiday weekend, day off or vacation, or while on a vacation, to be granted sick leave he shall be required to furnish a certification as to the incapacity from a regularly licensed physician. The Department head may require certification for such other period of illness he deems advisable. If the certification required is not furnished, all absence which would have been covered by such certification shall be indicated on the payroll as leave of absence WITHOUT PAY.

Sick leave taken for trivial indispositions, or falsification of an illness report shall be considered sufficient cause for DISMISSAL from the government services.

I CERTIFY THAT THE ABOVE NAMED PERSON WAS UNDER MY PROFESSIONAL CARE OR QUARANTINED 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 FOR WORK.

FROM (Hour, Month, Day, Year)	TO (Hour, Month, Day, Year	HOSPITALIZED? ☐ YES ☐ NO	NO. DAYS

REMARKS

NAME OF PHYSICIAN (Print or Type)	(Signature of Physician)
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT.	(Signature of Employee)
☐ APPROVED ☐ DISAPPROVED	(Signature of Supervisor)
☐ APPROVED ☐ DISAPPROVED	(Signature of appointing or authorized delegate)

LEAVE APPLICATION
GMHA From #0735 Stock # 990735
Approved Date:
Revised Date: