GUAM MEMORIAL HOSPITAL AUTHORITY
850 Gov. Carlos G. Camacho Road
Tamuning, Guam 96911

SICK/ANNUAL LEAVE DONATION REQUEST FOR MEDICAL EMERGENCY REASONS

	Leave Recipient Information	Leave Donor Information
1. Employee Name		
2. Social Security No.		
3. Class Title/Pay Grade/Step		
4. Agency		
Division		

5. **Donated Leave Period:** From: _____ To: _____
Total Hours: _____ Sick Leave or Annual Leave (Circle One) Leave must be 10 consecutive working days

6. **Certification of Leave Recipient:**
Explanation of Illness/Injury: _____
_____
_____

I hereby certify that I have secured permission from my agency to use donated sick/annual leave pursuant to the leave sharing procedures. This request is due to the above referenced illness/injury and will be used during the dates listed above in order to continue my compensation. I understand that my own accrued leave will be exhausted first before receiving the donated leave.

Leave Recipient: _____ Date: _____

Department Supervisor: _____ Date: _____

7. **Certification from Leave Recipient's Payroll Supervisor:**

A. I certify that the employee requesting for donated leave has accrued the following hours to his/her leave account.

_____	Annual Leave Balance for PPE	_____
_____	Sick Leave Balance for PPE	_____
_____	Compensatory Balance for PPE	_____
_____	Other: _____	_____

Payroll Supervisor: _____ Date: _____

8. **Certification of Leave Donor:**

A. I hereby certify that I am voluntarily donating the leave hours on item #5 and request that my Payroll Supervisor transfer the above listed hours of my sick / annual leave to the Leave Recipient listed above.
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Leave Donor: _____ Date: _____

B. I hereby certify that the donor has accrued the amount of leave to be donated.

_____	Annual Leave Balance for PPE	_____
_____	Sick Leave Balance for PPE	_____

Payroll Supervisor: _____ Date: _____

9. **[ ] APPROVED [ ] DISAPPROVED**

Recipients Appointing Authority: _____ Date: _____
Lillian Q. Perez-Posadas, MN, RN Hospital Administrator/CEO

REVISED 08/15/15