GUAM WATERWORKS AUTHORITY

Suite 200, Gloria B. Nelson Public Service Building 688 Route 15, Mangilao, Guam 96913

GOVERNMENT OF GUAM

LEAVE APPLICATION FORM

NAME (First, Middle, Last)	BADGE NUMBER	DATE OF REQUEST:

TYPE OF LEAVE REQUESTED

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

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 PREPAID:

SICK LEAVE CERTIFICATION

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.

FROM: (Month, Day, Year)	TO: (Month, Day, Year)	TOTAL NO. OF DAYS:

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