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 — 3GCA, Chapter 9, §9125

☐ 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