



RESEARCH CORPORATION of the University of Guam

Leave Application

PPE: ___/___/___ [] hours

PPE: ___/___/___ [] hours

FILE COPY

NAME (First, Middle, Last)		COLLEGE / UNIT	DATE
TYPE OF LEAVE [] Sick [] Annual [] Administrative [] Pregnancy - Related Med [] Parental [] LWOP		REQUESTED [HRS] [] Jury [] Military [] Other (specify)	
PAY STATUS [Calculates Automatically] Number of Hours with Pay:		Without ay:	Total Number of Hours:
FROM (Hour, Month, Day, Year)		TO (Hour, Month, Day, Year)	
REASON			

NOTE: For rules and regulations pertaining to absence from duty, refer to the appropriate personnel policies: (1) Government of Guam Civil Service Personnel Rules and Regulations (classified employees), and (2) University of Guam Personnel Rules and Regulations (academic/non-classified employees).

DOCTOR'S SICK LEAVE CERTIFICATION

I certify that the above-named person was under my professional care or quarantined during the period stated below.

FROM (Month, Day, Year)	TO (Month, Day, Year)	HOSPITALIZED: YES	NO
REMARKS (State limitations, if any)			
NAME OF PHYSICIAN (Print or type)		SIGNATURE OF PHYSICIAN	

APPLICATION OF PREPAYMENT OF LEAVE

FROM (Month, Day, Year)	TO (Month, Day, Year)	TOTAL HOURS PREPAID		
SIGNATURE OF EMPLOYEE		DATE		
I certify all statements made herein are true and correct.				
APPROVED	DISAPPROVED	NAME OF CHAIR/SUPERVISOR	SIGNATURE	DATE
APPROVED	DISAPPROVED	NAME OF APPROPRIATE ADMINISTRATOR	SIGNATURE	DATE

V. 10.20.16



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PAYROLL COPY

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