FILE COPY

UNIVERSITY OF GUAM
Leave Application

PPE: ___/___/___ [ ] hours
PPE: ___/___/___ [ ] hours

NAME (First, Middle, Last)	COLLEGE / UNIT	DATE

TYPE OF LEAVE [ ]Sick [ ] Annual [ ]Administrative [ ]Maternity [ ]Parental [ ]LWOP
REQUESTED [HRS] [ ]Jury [ ] Military [ ]Bereavement [ ]Paternity [ ]Other (specify)

PAY STATUS [Calculates Automatically] Number of Hours with Pay: **16** Without Pay: **0** Total Number of Hours: **16**

FROM (Hour, Month, Day, Year) **8:00 am, 8/31/2018** TO (Hour, Month, Day, Year) **5:00 pm, 9/4/2018**

REASON **Medical & Leave**

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

I certify all statements made herein are true and correct. SIGNATURE OF EMPLOYEE DATE

☐ APPROVED ☐ DISAPPROVED NAME OF CHAIR/SUPERVISOR SIGNATURE DATE

☐ APPROVED ☐ DISAPPROVED NAME OF APPROPRIATE ADMINISTRATOR SIGNATURE DATE
Thomas W. Krise, President

V. 10.20.16

PAYROLL COPY

UNIVERSITY OF GUAM
Leave Application

PPE: ___/___/___ [ ] hours
PPE: ___/___/___ [ ] hours

NAME (First, Middle, Last)	COLLEGE / UNIT	DATE

TYPE OF LEAVE [ ]Sick [ ] Annual [ ]Administrative [ ]Maternity [ ]Parental [ ]LWOP
REQUESTED [HRS] [ ]Jury [ ] Military [ ]Bereavement [ ]Paternity [ ]Other (specify)

PAY STATUS [Calculates Automatically] Number of Hours with Pay: **16** Without Pay: **0** Total Number of Hours: **16**

FROM (Hour, Month, Day, Year) **8:00 am, 8/31/2018** TO (Hour, Month, Day, Year) **5:00 pm, 9/4/2018**

REASON **Medical & Leave**

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

I certify all statements made herein are true and correct. SIGNATURE OF EMPLOYEE DATE

☐ APPROVED ☐ DISAPPROVED NAME OF CHAIR/SUPERVISOR SIGNATURE DATE

☐ APPROVED ☐ DISAPPROVED NAME OF APPROPRIATE ADMINISTRATOR SIGNATURE DATE
Thomas W. Krise, President

V. 10.20.16