

UNIVERSITY OF GUAM
Leave Application

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

FILE COPY

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: Without Pay: 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
I certify all statements made herein are true and correct.		DATE
SIGNATURE OF EMPLOYEE		DATE
APPROVED DISAPPROVED	NAME OF CHAIR/SUPERVISOR	SIGNATURE DATE
APPROVED DISAPPROVED	NAME OF APPROPRIATE ADMINISTRATOR	SIGNATURE DATE

V. 10.20.16

UNIVERSITY OF GUAM
Leave Application

PPE: ___/___/___ [] hours
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PAYROLL COPY

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V. 10.20.16