# Office of the Attorney General of Guam

## LEAVE APPLICATION FORM

Hon. Leevin Taitano Camacho
Attorney General of Guam

| Finance & Payroll Section | Division Code: _____ PPE: |
|---|---|

| NAME: | SOCIAL SECURITY NO.: | DATE OF REQUEST: |
|---|---|---|
| First Middle Last | XXX – XX – _____ Last four digits | Month / Day / Year |

☐ ANNUAL ☐ SICK ☐ LEAVE WITHOUT PAY ☐ LEAVE SHARE (SL) (AL)

☐ COMPENSATORY TIME OFF ☐ OTHER _____

☐ ADMINISTRATIVE: ☐ Training (Local) (Off-Island) Event: _____

☐ Jury ☐ Parental Involvement ☐ Parental (Maternity/Paternity)

☐ Family Medical Leave Act (FMLA) ☐ Military ☐ Military Leave Without Pay

☐ Wellness Program ☐ Bereavement ☐ Other _____

### LEAVE PERIOD

| FROM: | TO: | TOTAL HOURS REQUESTED: |
|---|---|---|
| Hour , Month Day Year | Hour , Month Day Year | |

ADDRESS WHILE ON LEAVE:

### EMPLOYEE CERTIFICATION REGARDING SICK LEAVE

I certify that for the period of time I am requesting sick leave, I was not feeling well, obtaining medical consult, receiving or scheduled to receive medical care, or tending to an ill family member. If required by my supervisor, I will submit certification from a health care provider confirming the need for medical attention or care. I agree that if I am required to submit certification from a health care provider and fail to do so, my request for sick leave may be denied and I will be charged annual leave or placed on leave without pay for the hours I was absent from work.

SIGNATURE OF EMPLOYEE:

___ APPROVED ___ APPROVAL PENDING SUBMISSION OF: ___ BIRTH CERTIFICATE ___ DEATH ANNOUNCEMENT

___ DISAPPROVED ___ MILITARY ORDERS ___ PHYSICIAN CERTIFICATION

___ PARENTAL INVOLVEMENT SLIP ___ OTHER

| NAME/SIGNATURE OF IMMEDIATE SUPERVISOR | DATE | NAME/SIGNATURE OF DIVISION HEAD | DATE |
|---|---|---|---|

___ APPROVED
___ DISAPPROVED

Sick Leave: Physician Certification Required: ___ YES ___ NO

SIGNATURE OF AUTHORIZED OFFICIAL OR APPOINTING AUTHORITY DATE

RECEIVED
Finance & Payroll

Time Date Initial

*REVISED **04**/2019*