

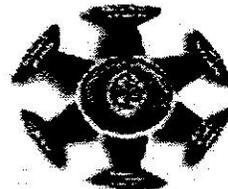


Felix P. Camacho  
Governor  
Michael W. Cruz, M.D.  
Lieutenant Governor

GOVERNMENT OF GUAM  
(GUBETNAMENTON GUAHAN)

DEPARTMENT OF ADMINISTRATION  
(DIPATTAMENTON ATMENESTRASION)

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Lourdes M. Perez  
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NOV 28 2007

Department of Administration Organizational Circular No. 08-006

To: All Department and Agency Heads  
From: Director, Department of Administration  
Subject: Amended Provisions  
RE: Leave Sharing Procedures

Buenas yan Hafa Adai! This circular has reference to the amendments made to §4109.2 (b) Voluntary Transfer of Sick Leave or Annual Leave pursuant to Section 96, Chapter VI Miscellaneous Provisions of Public Law 29-19 effective October 1, 2007. Please be advised of the following changes as numbered:

- 1) If a government of Guam employee desires to transfer a number of hours of earned sick leave or annual leave to another employee in any department or agency of the government, the **recipient** must first exhaust all accrued annual and sick leave, and compensatory time for the purposes of a medical emergency or for personal reasons. However, in applying donated sick leave, please be aware of the provisions of §4108(c) 1 & 2, which identifies when sick leave with pay is allowed. As a result, the voluntary transfer of sick leave for other than its intended purposes is prohibited.

4108(c) 1 provides:

The employee is compelled to be absent from duty on account of physical or mental illness; injury; mental health examination, counseling or treatment; pregnancy; childbirth; medical, dental or optical examination or treatment; or because of quarantine due to his own or another's illness.

4108(c) 2 provides:

The employee is compelled to be absent from duty to provide health care for a member of the employee's immediate family as a result of serious illness or injury and the employee has exhausted all annual leave and compensatory time available. Serious illness or injury means an urgent condition that is certified by the attending physician as requiring hospitalization, institutionalization, or extended home care in which the person needs the constant administration of special medical care or support.

- 2) Leave transferred from *donors* whose *hourly rates of pay or salaries* are lower than the *recipient* shall be paid at the *hourly rate or salary* of the *donor*.

Leave transferred from *donors* whose *hourly rates of pay or salaries* are higher than the *recipient*, shall be paid at the *hourly rate or salary* of the *recipient*.

The extent of the above provision will be applied based in the following manner and where applicable:

Recipient's hourly rate is \$21.18. The Donor's hourly rate is \$16.55. The number of donated leave hours is 50. The 50 hours of leave donated will be paid out at the donor's hourly rate of \$16.55 pursuant to the amended provisions of §4109.2 (b).

Recipient's hourly rate is \$16.55. The Donor's hourly rate is \$21.18. The number of donated leave hours is 50. The 50 hours of leave donated will be paid out at the recipient's hourly rate of \$16.55 pursuant to the amended provisions of §4109.2 (b).

- 3) Participation in the leave-sharing program *shall not exceed* ninety (90) working days. (Previous provision provided "*shall not exceeding...*")

Based on the changes made to §4109.2(b), please use the attached amended leave sharing request forms.

Effective immediately, to ensure compliance of the Leave Sharing Program requirements, pursuant to PL 29-19, all approved and disapproved leave-sharing requests effective October 1, 2007 and thereafter for medical emergency reasons shall be forwarded to the Human Resources Division for compliance review purposes.

Should you have any questions, please contact our Employee Management Relations Branch of the Human Resources Division at 475-1249 or 475-1288. Si Yu'os Ma'ase.

  
LOURDES M. PEREZ

Attachments

GOVERNMENT OF GUAM  
DEPARTMENT OF ADMINISTRATION  
SICK/ANNUAL LEAVE DONATION REQUEST FOR MEDICAL EMERGENCY REASONS

	LEAVE RECIPIENT	LEAVE DONOR
1. EMPLOYEE NAME		
2. SOCIAL SECURITY NO.		
3. CLASS TITLE & PAYGRADE		
4. HOURLY RATE/SALARY		
5. AGENCY/DIVISION		

6. Donated Leave Period: FROM-TO: \_\_\_\_\_ Total Hours: \_\_\_\_\_ SL/AL

7. Explanation of Illness/Injury: \_\_\_\_\_  
\_\_\_\_\_

I hereby certify that I have secured permission from my agency to use donated sick and/or annual leave pursuant to the leave sharing procedures. This request is due to the above referenced illness/injury and will be used during the dates listed above in order to continue my compensation. I understand that my own accrued leave will be exhausted first before receiving the donated leave.

Certification of Leave: \_\_\_\_\_ Date: \_\_\_\_\_

**Recipient's Signature**

**8. CERTIFICATION FROM LEAVE RECIPIENT'S CHIEF PAYROLL OFFICER**

A. I certify that the employee requesting for donated leave has accrued the following hours to his/her leave account.

- ANNUAL LEAVE                      Balance: \_\_\_\_\_ PPE: \_\_\_\_\_
- SICK LEAVE                              Balance: \_\_\_\_\_ PPE: \_\_\_\_\_
- COMPENSATORY TIME                  Balance: \_\_\_\_\_ PPE: \_\_\_\_\_

Chief Payroll Officer/Authorized Designee: \_\_\_\_\_ Date: \_\_\_\_\_

**9. CERTIFICATION OF LEAVE DONOR**

A. I hereby certify that I am voluntarily donating leave hours on item 6 above and request that my Chief Payroll Officer transfer the above listed hours of my sick/annual leave to the Leave Recipient listed above. I understand that a minimum of one pay period of balance will be retained in my leave account for my personal use.

Leave Donor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

B. I hereby certify that the Donor has accrued the amount of leave to be donated in addition to the required one pay period of leave which must remain in the Donor's leave account.

- ANNUAL LEAVE                      Balance: \_\_\_\_\_ PPE: \_\_\_\_\_
- SICK LEAVE                              Balance: \_\_\_\_\_ PPE: \_\_\_\_\_

Chief Payroll Officer/Authorized Designee: \_\_\_\_\_ Date: \_\_\_\_\_

10.     APPROVED                       DISAPPROVED

Recipient's Appointing Authority: \_\_\_\_\_ Date: \_\_\_\_\_  
(Please Print Name & Title)

DOA HRD EMR (Initial/Date): \_\_\_\_\_

GOVERNMENT OF GUAM  
DEPARTMENT OF ADMINISTRATION  
ANNUAL LEAVE DONATION REQUEST FOR PERSONAL REASONS

	LEAVE RECIPIENT	LEAVE DONOR
<b>1. EMPLOYEE NAME</b>		
<b>2. SOCIAL SECURITY NO.</b>		
<b>3. CLASS TITLE &amp; PAYGRADE</b>		
<b>4. HOURLY RATE/SALARY</b>		
<b>5. AGENCY/DIVISION</b>		

6. Donated Leave Period: FROM-TO: \_\_\_\_\_ Total Hours: \_\_\_\_\_ AL

7. Authorized Personal Reason(s): \_\_\_\_\_

I hereby certify that I have secured permission from my agency to use donated annual leave pursuant to the leave sharing procedures. This request is due to the above referenced personal reason(s) and will be used during the dates listed above in order to continue my compensation because my own accrued leave will be exhausted first before receiving the donated leave.

Certification of Leave: \_\_\_\_\_ Date: \_\_\_\_\_

**Recipient's Signature**

**8. CERTIFICATION FROM LEAVE RECIPIENT'S CHIEF PAYROLL OFFICER**

A. I certify that the employee requesting for donated leave has accrued the following hours to his/her leave account.

ANNUAL LEAVE Balance: \_\_\_\_\_ PPE: \_\_\_\_\_

COMPENSATORY TIME Balance: \_\_\_\_\_ PPE: \_\_\_\_\_

Chief Payroll Officer/Authorized Designee: \_\_\_\_\_ Date: \_\_\_\_\_

B. I hereby certify for the Recipient Agency listed above that this request meets the guidelines for donating annual leave pursuant to the leave sharing procedures. I authorize my agency to add the total hours donated above to the Recipient Employee listed.

Recipient's Appointing Authority: \_\_\_\_\_ Date: \_\_\_\_\_  
(Please Print Name & Title)

**9. CERTIFICATION OF LEAVE DONOR**

A. I hereby certify that I am voluntarily donating leave hours on item 6 above and request that my Chief Payroll Officer transfer the above listed hours of my annual leave to the Leave Recipient listed above. I understand that a minimum of one pay period of balance will be retained in my leave account for my personal use.

Leave Donor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

B. I hereby certify that the Donor has accrued the amount of leave to be donated in addition to the required one pay period of leave which must remain in the Donor's leave account.

ANNUAL LEAVE Balance: \_\_\_\_\_ PPE: \_\_\_\_\_

Chief Payroll Officer/Authorized Designee: \_\_\_\_\_ Date: \_\_\_\_\_

10.  APPROVED  DISAPPROVED

Director of Administration: \_\_\_\_\_ Date: \_\_\_\_\_

DOA HRD EMR (Initial/Date): \_\_\_\_\_

LVSH-PERS Amended: PL29-19 10/1/07(2)



# AFFIDAVIT

THIS IS TO CERTIFY THAT, FOR THE PURPOSE OF RECEIVING DONATED LEAVE FOR A PERSONAL REASON, I AM INVOLVED IN ONE OF THE APPROVED REASONS FOR DONATED LEAVE LISTED BELOW: (Check One)

- 1. Adopting a child or placing a child up for adoption.
- 2. Undergoing divorce or separation proceedings.
- 3. Death of a family member:  
Name of Deceased: \_\_\_\_\_  
Relationship to Employee: \_\_\_\_\_ Date of Death: \_\_\_\_\_
- 4. Undergo Cosmetic and/or voluntary surgery.
- 5. Temporary care of child or children until permanent child care arrangements can be made. (Child's Name & Age)
- 6. Take care of legal commitments.
- 7. Return to school, take additional training and other educational programs.
- 8. Temporary care of an elderly or physically/mentally disabled member of the family.

Name of Family Member: \_\_\_\_\_  
Relationship to Employee: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

9. OTHER: (Specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING STATEMENT IS TRUE AND CORRECT.

\_\_\_\_\_  
EMPLOYEE'S SIGNATURE                      DATE

GUAM                      )  
                                  )  
CITY OF AGANA        )

ss

On this \_\_\_\_\_ day of \_\_\_\_\_, before me, a Notary Public in and for Guam, personally appeared \_\_\_\_\_, and he/she acknowledged to me that he/she executed the foregoing instrument, as his/her voluntary act and deed for the purposes therein set forth.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year first above written.

< S E A L >

\_\_\_\_\_  
NOTARY PUBLIC

My Commission Expires: