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

DEPARTMENT OF ADMINISTRATION
(DIPATTAMENTON ATMENESTRASION)
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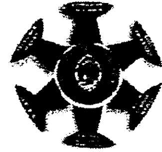

Lourdes M. Perez
Director
Joseph C. Manibusan
Deputy Director

DEPARTMENT OF ADMINISTRATION ORGANIZATIONAL CIRCULAR NO. 2009-023

AUG 27 2009

To: All Line Departments and Agencies

From: Director, Department of Administration

Subject: **LEAVE APPLICATION FORM**

Buenas! This circular is in reference to the government of Guam's leave application form, which we have amended to reflect and include a new training code.

It has been the government's practice that when a government employee is approved to attend official training in line with his/her work, the employee's time spent in training is generally compensable working time and the employee is not charged his/her personal leave. Therefore, to ensure compliance with this regulation, if any government employee is approved to attend training away or outside of his/her working area whether local or off-island, i.e. DOA Training Rooms, other government agencies/departments, hotels or public training facilities, the government employee must use and fill out the appropriate box on the leave application form and submit to his/her supervisor or designated approving authority.

The attached revised leave form will be forwarded to the General Services Agency for printing and distribution.

For your convenience, please find attached a copy of amended government of Guam Leave Application Form. Should you have any questions, please contact the Employee-Management Relations Branch at 475-1138 or 475-1249. Si Yu'os Ma'ase.

LOURDES M. PEREZ

Attachment

GOVERNMENT OF GUAM

LEAVE APPLICATION FORM

NAME (First, Middle, Last)	**SOCIAL SECURITY NO.:**	**DATE OF REQUEST:**

TYPE OF LEAVE REQUESTED

( ) ANNUAL ( ) SICK ( ) LEAVE W/O PAY ( ) COMP-TIME OFF ( ) TRAINING (LOCAL / OFF-ISLAND) ( ) OTHER

LEAVE PERIOD

FROM (Hour, Month, Day, Year)	**TO:** (Hour, Month, Day, Year)	**TOTAL HOURS REQUESTED:**

ADDRESS WHILE ON LEAVE:

APPLICATION FOR PREPAYMENT OF VACATION LEAVE

Minimum requirement is not less than ten (10) consecutive days. It is understood that if I return to duty before the expiration of my prepaid vacation. I shall reimburse the government in the amount equivalent to the unexpired portion of the prepaid leave.

FROM (Hour, Month, Day, Year)	**TO:** (Hour, Month, Day, Year)	**TOTAL HOURS PREPAID:**

SICK LEAVE CERTIFICATION

I certify that the above person was under my professional care or quarantine during the period stated below. From a medical standpoint, his/her condition during this period was such that I considered it inadvisable for him/her to report to work.

FROM: (Month, Day, Year)	**TO:** (Month, Day, Year)	**TOTAL NO. OF DAYS:**

REMARKS:

NAME OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL (TYPE OR PRINT)	**SIGNATURE OF LICENSED PHYSICIAN/HEALTH PROFESSIONAL**

SIGNATURE OF EMPLOYEE:

( ) APPROVED ( ) DISAPPROVED	( ) APPROVED ( ) DISAPPROVED
SIGNATURE OF IMMEDIATE SUPERVISOR	SIGNATURE OF AUTHORIZED OFFICIAL OR APPOINTING AUTHORITY