GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION

INSTRUCTIONS FOR COMPLETING FORM
Sick/Annual Leave Donation
Request for Medical Emergency Reasons

1. Enter the employee names, the Recipient first and then the Donor.

2. Enter the Social Security Numbers for both employees.

3. Enter the Class Title (position titles) of the employees and the associated Pay Grade/Step for each.

4. Enter each employee's Hourly Rate and Salary.

5. Enter each employee's Agency/Department and Division.

6. Enter the dates (From - To) for which the Donated Leave Period is to be used.

   NOTE: These dates must not be for a prior period of time as the request must be approved before leave can be taken. Also, enter the Total Hours to be used during this period of time (identify hours of leave [sick and/or annual leave] donated).

7. Explain the appropriate medical emergency reason (employee or employee's immediate family member) for which this leave will be used. The Recipient employee must sign and date the form.

8. To receive leave, the requesting employee (Recipient) must obtain certification from his/her agency/department Chief Payroll Officer/Authorized Designee on his/her leave account and total donated leave sharing approved and paid to date in accordance with the Leave Sharing Program.

9. To donating employee (Donor) must certify this request by signing, dating and indicating total leave (sick and/or annual leave) hours donating on the form. In addition, the Donor employee must obtain certification from his/her Chief Payroll Officer/Authorized Designee indicating the Donor has accrued the amount of leave to be donated in the Donor's leave account.

INSTRUCTION FOR RECIPIENT ON THE REQUIRED DOCUMENTATION

   A. The Recipient shall attach an original medical certification by a licensed practicing physician. (Employee or employee's immediate family member [certification must identify immediate family member's medical condition, relationship to employee and timeframe or time period]).

   B. Attach the approved Request for Leave (Form FCN 2-0-1) with all required signatures. Note: Absence must be for a minimum of ten (10) consecutive workdays for medical emergency reasons. To donate leave hours, the Donor employee must obtain certification from his/her Chief Payroll Officer/Authorized Designee indicating the Donor has accrued the amount of leave hours to be donated.

10. Recipient's Appointing Authority's printed name, position title and signature.

Clear Form

Print Form

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SICK/ANNUAL LEAVE DONATION REQUEST FOR MEDICAL EMERGENCY REASONS

	LEAVE RECIPIENT	LEAVE DONOR
1. EMPLOYEE NAME		
2. SOCIAL SECURITY NO.		
3. POSITION 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.

Recipient's Signature: _____ Date: _____

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: _____
- ☐ Other:_____ 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 and/or annual leave to the Leave Recipient listed above.

Leave Donor's Signature: _____ Date: _____

B. I hereby certify that the Donor has accrued the amount of leave to be donated.

- ☐ 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 & Signature)

DOA HRD EMR (Initial/Date): _____