EDWARD M. BIRN
Director (Direktot)
RENA K. BORJA
Deputy Director (Sigundo Direktot)

DEPARTMENT OF ADMINISTRATION

DIPATTAMENTON ATMENESTRASION

DIRECTOR'S OFFICE
(Ufisinan Direktot)
Telephone (*Telifon*): (671) 475-1101/1250

LOURDES A. LEON GUERRERO
Governor (Maga'håga)
JOSHUA F. TENORIO
Lt. Governor (Sigundo Maga'låhi)

WELCOME TO THE GOVERNMENT OF GUAM!

Dear New Employee,

Buenas yan Håfa Adai! On behalf of the Department of Administration, we are pleased to welcome you to the Government of Guam. Your role is vital to our mission and commitment to serving the people of Guam.

As part of your onboarding process, you will complete necessary forms and receive an overview of the benefits available to you as a government employee. These benefits are designed to support you and your family. To ensure seamless access to these resources and effective communication, it is important to **keep your personal information updated throughout your employment.**

It is your responsibility to review the Government of Guam's **Personnel Rules and Regulations**, which outline policies applicable to classified positions. These can be accessed at *https://hr.doa.guam.gov/resources/.*

If you have any questions or need assistance, do not hesitate to reach out to your supervisor or the Human Resources team. We are here to support you and ensure your success.

We are confident that your time with the Government of Guam will be both rewarding and fulfilling. We look forward to your contributions and to working together in service to our community.

Senseramente,

EDWARD M. BIRN
Director
Department of Administration

Enclosures:

New Employee Forms

GOVERNMENT OF GUAM
(GUBETNOMENTON GUAHAN)
DEPARTMENT OF ADMINISTRATION
(DIPATTAMENTON ATMENESTRASION)
PAYROLL SECTION
(SEKSION SUETO)
Post Office Box 884, Hagåtña, Guam 96932
Tel (671) 475-1195/1268 ~ Fax (671) 472-9794

AUTHORIZATION AGREEMENT FOR AUTOMATIC (DIRECT) DEPOSIT

EMPLOYEE'S NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER
MAILING ADDRESS (PO / ST NAME, CITY, STATE, ZIP)	**DEPT / AGENCY**
EMPLOYEE'S CONTACT NUMBERS	**DEPT. NO.**
WORK: **HOME:**	

PLEASE CHECK ONE BOX ONLY:

☐ **NEW ACCOUNT** ☐ **CHANGE ACCOUNT** ☐ **CANCEL ACCOUNT**

PAYROLL DIRECT DEPOSIT INFORMATION - ACTIVATION

Depository Type	Depository Bank Name	ABA Routing No.	Account #	Amount
☒ Checking ☐ Savings	SAMPLE BANK	Always 9 digits 123456789	000000XXX	Net Pay Amount
☐ Checking ☐ Savings				NET PAY AMOUNT

The ROUTING NUMBER can be obtained from your financial institution and in most cases it's printed on your check. Incorrect routing number may delay your funds being available to you on the check date. Limited to financial or banking institutions with local branches ONLY.

I hereby authorize the Department of Administration, Payroll Section, to TRANSACT the above effective pay period ending:

_____

EMPLOYEE Signature / Date

BANK REPRESENTATIVE Signature / Date

FOR PAYROLL SECTION USE ONLY			
RECEIVED BY:		**PROCESSED BY:**	
DATE RECEIVED:		**DATE PROCESSED:**	

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . 2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No 1615-0047
Expires 07 31 2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.)

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2. and 3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			Additional Information		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.		

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy)

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport, and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on I-9 Central for more information

Supplement A,
Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07 31 2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07 31 2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name _____ **Employer ID#** _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision
Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is $313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision
Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information
Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security benefits.

Signature of Employee _____ **Date** _____

Information about Social Security Form SSA-1945
Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/form1945. Paper copies can be requested by email at oplm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 ATTACHMENT 3

Appointment Affidavits

I, _____, do solemnly swear (or affirm) in the presence of Almighty
Name of Employee

God that while employed with _____,
Department

A. OATH OF OFFICE

I will well and faithfully support the Constitution of the United States, the laws of the United States applicable to Guam and the laws of Guam, and that I will conscientiously and impartially discharge my duties as an (officer) (employee) of the government of Guam.

B. AFFIDAVIT AS TO SUBVERSIVE ACTIVITY AND AFFILIATION

I do not advocate nor am I a member of any organization that advocates the overthrow of the Government of the United States or the government of Guam by force or violence or other unconstitutional means or seeking by force or violence to deny other persons their rights under the Constitution of the United States. I do further swear (or affirm) I will not so advocate, nor will I become a member of such organizations during the period that I am an employee of the government of Guam.

C. AFFIDAVIT AS TO PURCHASE AND SALE OF OFFICE

I have not paid, or offered or promised to pay any money or other things of value to any person, firm, or corporation for the use of influence to procure my appointment.

Subscribed and sworn before me this _____ day of _____, _____.

_____
SIGNATURE

_____ _____
WITNESS DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised June 15, 2009 **ATTACHMENT 4**

DESIGNATION OF SURVIVOR OR SURVIVORS FOR PAY WHICH WERE NOT DELIVERED TO EMPLOYEE DURING HIS/HER LIFETIME AND ACCUMULATED UNUSED ANNUAL AND SICK LEAVE UPON DEATH

Pursuant to the provision of Public Law 12-47, approved October 19, 1973, I hereby designate the hereinafter named as survivor or survivors of any amount of pay not delivered to me during my lifetime which may become refundable to me upon my death and for accumulated unused annual and sick leave converted to cash and credited to my account with the government of Guam and hereby authorize, empower and direct employer, government of Guam, to my payments.

Definition of Survivor or Survivors: one who survives another; one who outlives another; one who lives beyond some happening; one or two or more persons who lives after the death of the other or others.

The word "survivors" however, in connection with the power of one or two trustees to act, is used not only with reference to a condition arising where one of such trustees dies, but also as indicating a trustee who continues to administer the trust after his co-trustee is disqualified, has been removed, or refuses to act.

In order to facilitate the settlement of the accounts of deceased employees, money due an employee at time of death shall be paid to the person or persons surviving at the time of death, in the following order of precedence and payment bars recovery by another person of amounts so paid:

FIRST, to the beneficiary or beneficiaries designated by the employee in writing received by the employing department or agency before his death.

SECOND, if there is no designated beneficiary, to the widow or widower of the employee.

THIRD, if none of the above, to the child or children of the employee and descendants of deceased children by representation.

FOURTH, if none of the above, to the duly appointed legal representative of the estate of the employee.

Employee Name _____ Department _____

Social Security Number _____ Position Title _____

Address _____

ELECT OPTION 1 – If your intentions are to designate ONLY ONE survivor/beneficiary

SURVIVOR	SSN	ADDRESS	TELEPHONE NO.	RELATIONSHIP

ELECT OPTION 2 – If your intentions are to designate MORE THAN ONE survivor/beneficiary

SURVIVOR	SSN	ADDRESS	TELEPHONE NO.	RELATIONSHIP	PERCENT-AGE %

_____ _____
EMPLOYEE'S SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 ATTACHMENT 5

Prior Service
(Military and/or Government of Guam)

NAME: _____

MAIDEN NAME OR ANY OTHER
OFFICIAL NAME USED: _____

SOCIAL SECURITY NUMBER: _____

FOR ANNUAL LEAVE CREDIT ONLY

For all Employees hired AFTER APRIL 09, 1998
Only THREE YEARS of Military Service will be credited pursuant to Public Law 24-155

TYPE OF PRIOR SERVICE	DOCUMENT REQUIRED	INDICATE THE YEARS FROM	TO	TOTAL PRIOR SERVICE
Military	DD-214			

TYPE OF PRIOR SERVICE	DOCUMENT REQUIRED	NAME OF DEPARTMENT OR AGENCY	INDICATE THE YEARS FROM	TO
Government of Guam	Copies of Personnel Actions if previously employed			

[ ] NO PRIOR SERVICE

_____ _____
SIGNATURE DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 ATTACHMENT 6

New Employee Master Data Form

1. SOCIAL SECURITY NUMBER: _____

2. LAST NAME: _____
   FIRST NAME: _____
   MIDDLE NAME: _____

3. POSITION TITLE: _____

4. EMPLOYMENT TYPE (circle one):
   P = Probational T = Temporary C = Contract E = Elected
   L = Limited U = Unclassified M = Summer Trainee X = Exempted

5. DATE OF BIRTH: Month _____ Day _____ Year _____

6. SEX (circle one): M = Male F = Female

7. ETHNIC BACKGROUND (circle one):
   CH = Chamorro WH = Caucasian JE = Japanese HI = Hispanic FO = Filipino
   BL = African American MN = Micronesian CE = Chinese KN = Korean VE = Vietnamese
   NM = Northern Marianas OT = Other

8. EMPLOYMENT DATE: Month _____ Day _____ Year _____

9. CITIZENSHIP (circle one):
   1 = U.S. 2 = Alien 3 = Permanent Resident 4 = FSM 5 = Marshall Island

10. SERVICE LENGTH (ONLY FOR PRIOR GOVERNMENT OF GUAM EMPLOYMENT):
    Year _____ Month _____ Day _____

11. MARTIAL STATUS (circle one):
    M = Married D = Divorced W = Widow S = Single L = Legally Separated

12. EDUCATION (circle one):
    GD = GED HS = High School AA = Associate Degree
    BA = Baccalaureate Degree PD = Doctorate Degree MA = Masters
    JD = Juris Doctorate

13. IF MILITARY (circle one):/ No prior service:_____

Prior Active Components

A3 = Army Service
A4 = Prior Active Army Guard
C3 = Prior Coast Guard Reserve
F3 = Prior Air Force Service
F4 = Prior Active Air Force Reserve
M1 = Marines
M3 = Prior Marine Service
N2 = Prior Navy Service

Reserve Components

A1 = Army Guard
A2 = Army Reserve
C1 = Coast Guard
C2 = Coast Guard Reserve
F1 = Air Force Guard
F2 = Air Force Reserve
M2 = Marine Reserve
N1 = Navy Reserve

14. IF VETERAN (circle one): R = Retired D = Discharge

15. PAY GRADE: _____ STEP: _____

16. HOURLY PAY RATE: _____

17. ANNUAL SALARY: _____

18. DISABILITY (circle one): Y = Yes N = No

19. TYPE OF DISABILITY CONDITION:
Hearing Speech Vision Other (specify): _____

20. HOME ADDRESS: _____
(House Number) (Street Number)

CITY: _____ STATE: _____ ZIP CODE: _____

21. MAILING ADDRESS: _____
(Post Office Box or Home Delivery)

CITY: _____ STATE: _____ ZIP CODE: _____

22. TELEPHONE NUMBERS:

HOME	( )				-					
	Area Code									
WORK	( )				-					

23. POINT OF CONTACT:

NAME: _____

RELATIONSHIP: _____ CONTACT NUMBER: _____

ADDRESS: _____

_____ _____

EMPLOYEE'S SIGNATURE DEPARTMENT

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 6, 2022 ATTACHMENT 7

GROUP TERM LIFE INSURANCE PROGRAM

PRINT NAME	SSN/DOB	DATE OF HIRE

The government of Guam offers to its employees, as part of the government of Guam benefits package, Group Term Life Insurance Program. Please answer the following questions:

- Are you a transfer employee from another department/agency? If yes, Dept. _____ ☐ YES ☐ NO
- Are you also a GovGuam retiree? If yes, Dept. _____ ☐ YES ☐ NO

Retirement Plan? ☐ Defined Benefit ☐ Defined Contribution

You are automatically covered for the Basic $10,000 life insurance amount upon serving your six months of service, which is **PAID FOR BY THE GOVERNMENT OF GUAM**. An enrollment form must be completed upon serving your six months of consecutive service (entitlement date).

BENEFITS	PAYMENT	ELIGIBILITY TIMEFRAME
Basic $10,000	Paid by Government of Guam	After serving 6 months of consecutive service/Entitlement date
Supplemental	Optional/Paid by employee (Refer to brochure)	Within 31 days after serving 6 months
Dependent Coverage	Optional/Paid by employee (Refer to brochure)	Within 31 days after serving 6 months

IMPORTANT DATES TO REMEMBER:

BENEFITS	EMPLOYEE DATES
Basic $10,000 entitlement date (6 months after hire date)	
Supplemental Coverage 31 days after entitlement date	
Dependent Coverage 31 days after entitlement date	

If you do not make an election for supplemental and/or dependent coverage within 31 days and desire to enroll after, you must complete an Evidence of Insurability form satisfactory to the insurance company before you can become insured or you may enroll during the Open Enrollment Period.

I acknowledge receipt of the "Notification of Eligibility" which specifies my entitlement date and the *31 day deadline* to elect additional coverage for the Government of Guam Group Life Insurance
Program.

I understand that, it is my responsibility to make changes or cancellations to include changes in family status where I no longer have eligible dependents.

_____ _____
EMPLOYEE'S SIGNATURE DATE

_____ _____
WITNESS (Benefits Branch Only) DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised: May 6, 2022 **ATTACHMENT 8**

MEDICAL AND DENTAL INSURANCE AGREEMENT

PRINT NAME	SSN/DOB	DATE OF HIRE

Do you have other health insurance coverage, to include COBRA? ..... ☐ YES ☐ NO

Are you a dependent under a spouse's/common-law's coverage with GovGuam?..... ☐ YES ☐ NO
If yes, spouse's/common-law's Name and Department:_____

Are you a GovGuam retiree? ☐ YES ☐ NO **If yes, Department:**_____

I acknowledge that I was given the opportunity to participate in the Government of Guam sponsored Health Insurance Programs and understand that I have 31 days from my effective date of hire to enroll in the health insurance program. Otherwise, I must wait until the next general Open Enrollment Period or a HIPAA event to elect enrollment. My elections are as follows: (check the appropriate blocks):

MEDICAL INSURANCE

☐ **YES**, I wish to enroll in the GOVERNMENT OF GUAM'S GROUP MEDICAL INSURANCE PROGRAM.
Medical Plan _____

☐ **NO**, I do not wish to enroll in the GOVERNMENT OF GUAM'S GROUP MEDICAL INSURANCE PROGRAM.

☐ **I have not made a decision, but understand I have 31 days from my effective date of hire to elect coverage.**

DENTAL INSURANCE

☐ **YES**, I wish to enroll in the GOVERNMENT OF GUAM'S GROUP DENTAL INSURANCE PROGRAM.
Dental Plan _____

☐ **NO**, I do not wish to enroll in the GOVERNMENT OF GUAM'S GROUP DENTAL INSURANCE PROGRAM.

☐ **I have not made a decision, but understand I have 31 days from my effective date of hire to elect coverage.**

I understand that my rejection of coverage at this time will prevent me from obtaining coverage in the future except during the Open Enrollment Period or upon a qualifying event (HIPAA), i.e. marriage, birth of child, or termination of other coverage.

I hereby certify that in addition to the explanation given to me by the Benefits Branch, Human Resources Division, Department of Administration, I have carefully read all information booklets of each of the plans that are available.

NOTE: CERTAIN HEALTH PLANS HAVE A "LOCK IN PROVISION." EMPLOYEES MAY ONLY CANCEL CERTAIN MEDICAL/DENTAL INSURANCE DURING THE ANNUAL OPEN ENROLLMENT PERIOD.

RATES MAY INCREASE DURING THE ANNUAL OPEN ENROLLMENT PERIOD. FAILURE TO MAKE CHANGES WILL BE UNDERSTOOD AS A DESIRE TO CONTINUE YOUR EXISTING PLAN AT THE NEW RATE.

_____ _____
EMPLOYEE'S SIGNATURE DATE

_____ _____
WITNESS (Benefits Branch Only) DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 6, 2022 ATTACHMENT 8A

GOVERNMENT OF GUAM SECTION 125 CAFETERIA PLAN

PRINT NAME	SSN/DOB	DATE OF HIRE

The Government of Guam offers the Cafeteria Plan pursuant to Section 125 of the Internal Revenue Code that allows you to deduct qualified insurance premiums. Under this program, you will be able to pay for selected benefits with a portion of your paycheck before income taxes are withheld. This means that you will pay less tax and increase your take home pay. Insurance premiums eligible for Pre-Tax are health insurance, dental insurance, group-term life insurance, & supplemental health insurance.

Employees with qualifying deductions for medical, dental and/or life will automatically be a participant in the plan unless a form "not to participate" is submitted within 31 days from the date of hire. In accordance with IRS regulations, employees cannot change election and/or cancel elections during the Plan Year unless a qualifying status change occurs.

☐ **Automatic participation** in the Government of Guam Section 125 Cafeteria Plan, Pre-Tax Benefit. I understand that if I am not eligible during the time of processing, once qualifying deductions apply, program is effective. Status will automatically continue unless a form is completed to revoke prior selection during open enrollment or if a qualifying event occurs.

☐ **Elect not to participate** in the Government of Guam Section 125 Cafeteria Plan. I understand I need to complete the Government of Guam Section 125 Form indicating my desire NOT to participate. I further understand that this election will carry over every year until I actively sign up for the plan during the next open enrollment.

_____ _____
EMPLOYEE'S SIGNATURE DATE

_____ _____
WITNESS (Benefits Branch Only) DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised August 11, 2020 ATTACHMENT 9

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

PRINT NAME	SSN/DOB	DATE OF HIRE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law by President Clinton on August 21, 1996.

This law was designed to help employees who are enrolled in a health plan maintain access to health insurance coverage as they change employers or when they leave their employer and seek an individual health plan. Compliance requirements are placed on employer-sponsored group health plan, insurance companies and health maintenance organizations.

An important aspect of the HIPAA (effective June 1, 1997), is the "Certificate of Coverage" that is issued by the health plan(s). This Certificate is important in the event an employee terminates from a group health plan. The Certificate will provide evidence of continuous creditable coverage of 18 months or more, if applicable, to avoid any pre-existing condition exclusion. The Certificate will assist you in obtaining coverage for you and your family when you lose it as a result of the following:

- Upon termination/resignation
- When I cancel my group health insurance with the government of Guam

As an employee, I understand that by completing the proper documents, the government will inform the health plan in which I am enrolled with as a result of the above.

In addition, if a "Certificate of Coverage" is not provided to me, it is my responsibility to inform the Human Resources Division, Department of Administration.

This is to certify that I have read and understood my rights under the HIPAA as explained and provided by the Department of Administration, Employee Benefits Branch.

_____ _____

EMPLOYEE'S SIGNATURE DATE

_____ _____

WITNESS (Benefits Branch Only) DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 6, 2022 ATTACHMENT 10

ACKNOWLEDGEMENT OF INSURANCE PREMIUM OBLIGATION WHILE ON APPROVED LEAVE WITHOUT PAY STATUS

PRINT NAME	SSN/DOB	DATE OF HIRE

I understand that, while I am on **Approved Leave Without Pay (ALWOP)** status (sick and/or annual leave), I am responsible for paying premiums for Life and Health Insurance prior to going on this status on a bi-weekly basis:

- **Health Insurance:** I am responsible for both Government and employee premium(s) for the Group Medical and/or Dental Insurance prior to going on this status. I also understand that failure on my part to pay the premium(s) due while on Approved Leave Without Pay may result in denial of claims against the insurance company and/or termination.

- **Life Insurance:** I am responsible for payment for any supplemental and/or dependent coverage. The government of Guam will contribute its share of the basic premium cost for the life insurance program and will make such payment on a bi-weekly basis.

FMLA: ***PR&R 8.800/ 29 CFR 825-209*** If I invoke leave under the Family Medical Leave Act of 1993, I understand I will be responsible to pay my premiums only. In the event, I do not return to work after invoking the Family Medical Leave Act of 1993, I will pay back the government's contribution for my insurance.

Military Leave without Pay: ***4GCA, Ch. 8, §8137.2 & §8209.2 Employees on Active Duty***
I acknowledge that if I do not cancel my insurance coverage while on this status, the government of Guam will continue payment for both the employee and employer share for the health and life insurance. I understand that when I return to work from this status, deductions will continue under my payroll.

This is to certify that I have read and understood my insurance premium obligation in which I am responsible for paying premium payments for health and life insurance prior to going on Approved Leave Without Pay (LWOP) status. For payments on LWOP, I will contact the Department of Administration, Division of Accounts, at 671-477-5861, so that they may prepare a payment receipt for me to pay at Treasurer of Guam. I will provide a copy of my payment receipt to the Department of Administration, Employee Benefits Branch for my insurance records. I further understand that if I fail to make payment, my coverage for health and life insurance will be terminated due to non-payment.

_____ _____
EMPLOYEE'S SIGNATURE DATE

_____ _____
WITNESS (Benefits Branch Only) DATE

EDWARD M. BIRN
Director (Direktot)
RENA K. BORJA
Deputy Director (Sigundo Direktot)

DEPARTMENT OF ADMINISTRATION
DIPATTAMENTON ATMENESTRASION
DIRECTOR'S OFFICE
(Ufisinan Direktot)
Telephone (*Telifon*): (671) 475-1101/1250

LOURDES A. LEON GUERRERO
Governor (Maga'håga)
JOSHUA F. TENORIO
Lt. Governor (Sigundo Maga'låhi)

ATTACHMENT 10A

NEW EMPLOYEE PROCESSING APPOINTMENT
INSURANCE DIVISION

Buenas Yan Håfa Adai! Once again, welcome to the *Government of Guam*! This letter is a formal notification of appointment for all newly hired *Government of Guam* employees to attend the *New Employee Processing* with the *Department of Administration: Insurance Division.*

As part of onboarding and processing for all new employees, the next step includes processing for employee life and health insurance benefits. You are informed to attend the insurance processing as follows:

Location: *Department of Administration, Employee Break Room, 2nd floor, ITC Building*

When: *Every* **Tuesday, 10:30 AM (please arrive 10 minutes early)**

ID required: **Non-expired valid ID (driver's license, Real ID or passport)**

In the event that the Tuesday of the week falls upon a *Government of Guam* holiday or an event that would cause DOA to be closed for operations, processing will then be rescheduled on Wednesday of the week or the next available day of operations.

Please be made aware that, as employees of the *Government of Gua*m, it is the employee's responsibility to promptly meet the scheduled date and time of their processing. **Employees who fail to attend the allotted timeframe for their *New Employee Processing* will be required to attend the next following allotted availability. Failure to attend and complete the *New Employee Processing* may result in the possibility of delay in the employee's benefits processing as well as the processing of their payroll**.

EDWARD M. BIRN
Director (Direktot)
RENA K. BORJA
Deputy Director (Sigundo Direktot)

DEPARTMENT OF ADMINISTRATION
DIPATTAMENTON ATMENESTRASION
DIRECTOR'S OFFICE
(Ufisinan Direktot)
Telephone (*Telifon*): (671) 475-1101/1250

LOURDES A. LEON GUERRERO
Governor (Maga'håga)
JOSHUA F. TENORIO
Lt. Governor (Sigundo Maga'låhi)

ATTACHMENT 10B

NEW EMPLOYEE PROCESSING – INSURANCE DIVISION
NOTICE FOR INSURANCE PROCESSING

This is a notification to process for your medical, dental and life insurance benefits. As employees of the Government of Guam, it is your responsibility to promptly meet the scheduled date and time of their processing.

Employees who fail to attend the allotted timeframe for your New Employee Processing will be required to attend the next following allotted availability may result in the possibility of delay in benefits and payroll processing.

Please complete all fields below:

Name of Employee: _____

Department: _____

Preferred Contact Number: _____

Preferred Email Address: _____

For Official use ONLY

Effective Date of Hire: _____

_____ _____
Records Staff Initials Date

TO BE ATTACHED TO THE INSURANCE PACKET FOR RETRIEVAL BY INSURANCE DIVISION STAFF.

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 **ATTACHMENT 11**

Retirement Defined Contribution and Defined Benefit Plan

EMPLOYEE'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DATE OF HIRE

Pursuant to Public Law 28-141 Section 3 (d), an employee whose employment commences after October 1, 2005 and whose employment is purely temporary, seasonal, intermittent or part-time shall be a member of the Defined Contribution Retirement System unless the employee is eligible for re-admission to the existing retirement system.

Pursuant to Public Law 23-42, all new employees of the government of Guam who's employment commences on or after October 01, 1995, must participate in the Defined Contribution Retirement System as a condition of employment.

1. Have you had any prior service with the government of Guam before October 01, 1995.

   [ ] YES [ ] NO

   NOTE: IF NO, THEN YOU BELONG TO THE DEFINED CONTRIBUTION PLAN.

2. If yes, did you withdraw your retirement contribution?

   [ ] YES [ ] NO

   NOTE: IF YES, THEN YOU BELONG TO THE DEFINED CONTRIBUTION (DC) PLAN.
   IF NO, THEN YOU BELONG TO THE DEFINED BENEFIT (DB) PLAN.

With my signature below I certify that I was informed by the Department of Administration, Human Resources Division, to process with the Government of Guam Retirement Fund.

_____ _____
EMPLOYEE'S SIGNATURE DATE

_____ _____
WITNESSED BY DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised January, 2018 ATTACHMENT 12

Government of Guam Retirement Plan Determination

PLEASE COMPLETE THE FOLLOWING AND REQUEST FOR VERIFICATION FROM RETIREMENT FUND			
EMPLOYEE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DATE OF HIRE

FOR THE GOVERNMENT OF GUAM RETIRMENT FUND USE ONLY

The above employee is eligible to participate in one of the following Government of Guam retirement plans:

[ ] Defined Benefit (DB) Plan

[ ] Defined Contribution (DC) Plan

[ ] Defined Benefit 1.75 (DB 1.75) Plan

[ ] Guam Retirement Security Plan (GRSP)

VERIFICATION MADE BY:

_____
PRINT NAME

_____
SIGNATURE

_____
DATE

UPON COMPLETION, PLEASE RETURN THIS FORM TO THE DEPARTMENT OF ADMINISTRATION, HUMAN RESOURCES DIVISION, RECORDS BRANCH.

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 **ATTACHMENT 13**

Report of Medical Examination – Retirement Copy

THIS REPORT OF MEDICAL EXAMINATION MUST BE COMPLETED AND SUBMITTED WITHIN 60 DAYS OF YOUR EFFECTIVE DATE OF HIRE. FAILURE TO DO SO IS SUBJECT TO TERMINATION.

1. DEPARTMENT:		2. DATE OF EXAM:
3. NAME:		4. SOCIAL SECURITY NO.:
5. SEX: M F	6. DATE OF BIRTH:	7. PLACE OF BIRTH:
8. ADDRESS (Number, Street, or RFD, City, State):		
9. NEXT OF KIN (Please indicate address and relationship):		
10. RACE:	11. CURRENT POSITION TITLE:	

ITEMS BELOW ARE TO BE COMPLETED BY HEALTH CARE PROFESSIONALS ONLY

12. HEARING: RT LT	13. VISION: RT 20/CORRECT TO 20/20: LT 20/CORRECT TO 20/20:	14. BUILD [ ] Slender [ ] Heavy [ ] Medium [ ] Obese
15. TEMPERATURE:		16. PULSE:
17. RESPIRATION:		18. BLOOD PRESSURE:
19. HEIGHT:		20. WEIGHT:
21. HAIR COLOR:		22. EYE COLOR:

CLINICIAN: Please check appropriate box and describe any abnormality as applicable

AREA OF EXAMINATION	NORMAL	ABNORMAL	NOT EXAMINED	DESCRITION OF ABNORMALITY
23. HEAD, FACE SCALP				
24. NOSE, MOUTH, THROAT				
25. EARS 26. EYES – GENERAL				
27. OPTHALMOSCOPIC				
28. NECK				
29. CHEST				
30. LUNGS				
31. BREASTS				
32. HEART				
33. VASCULAR SYSTEM				
34. ABDOMEN				
35. ANUS, RECTUM				

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 **ATTACHMENT 13**

Report of Medical Examination – Retirement Copy

36. GENITALIA				
37. UPPER EXTREMITIES (Strength, Range of Motion, Peripheral Pulses)				
38. LOWER EXTREMITIES (Strength, Range of Motion, Peripheral Pulses)				
39. SPINE & OTHER MUSCULOSKELETAL				
40. IDENTIFICATIONS, SCARS, BODY MARKS, TATTOOS				
41. SKIN				
42. PELVIC/PAP (Females Only)				
43. PROSTATE (Males Only)				

ALL ITEMS BELOW THIS LINE ARE TO BE COMPLETED BY PHYSICIAN

44. PPD DATE: RESULTS:	45. IMMUNIZATIONS:

46. OTHER TESTS: Only if indicated

a. CBC (No Differential)	d. Hemoccult	g. Chest X-Ray
b. Fasting Blood Sugar	e. Hepatitis Screening	h. Other
c. Urinalysis	f. Cholesterol	

47. REMARKS: Clinical Evaluation Comments, Recommendations, Summary of Physical Defects & Diagnosis: (Use additional sheets of plain paper if necessary)

48. RESULTS ON THE BASIS OF THIS EXAMINATION:

[ ] Is physically fit for this position.

[ ] is NOT physically fit for this position.

49. PRINT NAME OF EXAMINING PHYSICIAN

50. SIGNATURE OF EXAMINING PHYSICIAN	51. DATE

52. ADDRESS OF EXAMINING PHYSICIAN (Number, Street, or RFD City, State)

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 **ATTACHMENT 14**

Report of Medical Examination – Human Resources Division

THIS REPORT OF MEDICAL EXAMINATION MUST BE COMPLETED AND SUBMITTED WITHIN 30 DAYS OF YOUR EFFECTIVE DATE OF HIRE. FAILURE TO DO SO IS SUBJECT TO TERMINATION.

DUE DATE: _____ **ISSUE DATE:** _____

1. DEPARTMENT:		2. DATE OF EXAM:
3. NAME:		4. SOCIAL SECURITY NO.:
5. SEX: M F	6. DATE OF BIRTH:	7. PLACE OF BIRTH:
8. ADDRESS (Number, Street, or RFD, City, State):		
9. NEXT OF KIN (Please indicate address and relationship):		
10. RACE:	11. CURRENT POSITION TITLE:	

ITEMS BELOW ARE TO BE COMPLETED BY HEALTH CARE PROFESSIONALS ONLY

12. HEARING: RT LT	13. VISION: RT 20/CORRECT TO 20/20: LT 20/CORRECT TO 20/20:	14. BUILD [ ] Slender [ ] Heavy [ ] Medium [ ] Obese
15. TEMPERATURE:		16. PULSE:
17. RESPIRATION:		18. BLOOD PRESSURE:
19. HEIGHT:		20. WEIGHT:
21. HAIR COLOR:		22. EYE COLOR:

CLINICIAN: Please check appropriate box and describe any abnormality as applicable

AREA OF EXAMINATION	NORMAL	ABNORMAL	NOT EXAMINED	DESCRITION OF ABNORMALITY
23. HEAD, FACE SCALP				
24. NOSE, MOUTH, THROAT				
25. EARS				
26. EYES – GENERAL				
27. OPTHALMOSCOPIC				
28. NECK				
29. CHEST				
30. LUNGS				
31. BREASTS				
32. HEART 33. VASCULAR SYSTEM				
34. ABDOMEN				
35. ANUS, RECTUM				

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 **ATTACHMENT 14**

Report of Medical Examination – Human Resources Division

36. GENITALIA				
37. UPPER EXTREMITIES (Strength, Range of Motion, Peripheral Pulses)				
38. LOWER EXTREMITIES (Strength, Range of Motion, Peripheral Pulses)				
39. SPINE & OTHER MUSCULOSKELETAL				
40. IDENTIFICATIONS, SCARS, BODY MARKS, TATTOOS				
41. SKIN				
42. PELVIC/PAP (Females Only)				
43. PROSTATE (Males Only)				

ALL ITEMS BELOW THIS LINE ARE TO BE COMPLETED BY PHYSICIAN

44. PPD DATE: RESULTS:	45. IMMUNIZATIONS:

46. OTHER TESTS: Only if indicated

a. CBC (No Differential)	d. Hemoccult	g. Chest X-Ray
b. Fasting Blood Sugar	e. Hepatitis Screening	h. Other
c. Urinalysis	f. Cholesterol	

47. REMARKS: Clinical Evaluation Comments, Recommendations, Summary of Physical Defects & Diagnosis: (Use additional sheets of plain paper if necessary)

48. RESULTS ON THE BASIS OF THIS EXAMINATION:

[ ] Is physically fit for this position.

[ ] Is NOT physically fit for this position.

49. PRINT NAME OF EXAMINING PHYSICIAN

50. SIGNATURE OF EXAMINING PHYSICIAN	51. DATE

52. ADDRESS OF EXAMINING PHYSICIAN (Number, Street, or RFD City, State)

DRUG-FREE WORKPLACE PROGRAM
GENERAL NOTICE FORM

The Department of Administration (DOA) has established and updated a drug-free workplace policy for Government of Guam applicants and employees under the direction of the Executive Branch, pursuant to current and subsequent Executive Orders such as E.O. 2025-03, relevant Guam laws and the DOA Personnel Rules & Regulations. All applicants/persons offered a job in the government must undergo and pass a drug test conducted under the authority of the DOA before working as a condition of employment. Employees must refrain from possessing, distributing, using, or be inhibited by illegal, or prohibited drugs, or alcohol while on duty, in the workplace and at the worksite. The Department of Administration's Drug-Free Workplace Program (DFWP) is designed to accomplish this goal through deterrence, identification, rehabilitation, and disciplinary action. Illegal, or prohibited drugs, or alcohol use could adversely affect employees, as well as public safety, risk damage to government and personal property, and significantly impair day- to-day operations.

Applicants and employees subject to testing are to provide the minimum amount of urine specimen necessary as specified by authorized specimen collectors in a restroom facility. However, when there is reason to believe that the specimen may be altered, the collection will be conducted under direct observation, which is gender based. The collection of specimens other than urine may be required such as for alcohol testing. The types of testing authorized by the DOA include but are not limited to the following:

a. **Pre-employment**: Initial hire into the government, re-employment, reappointment, and includes the drug testing of an active employee from an autonomous agency who did not previously pass drug testing conducted under the DOA's DFWP and is being hired by a line department/agency with no break in service.

b. **Random**: Employees occupying a safety sensitive position known as Testing Designated Positions "TDPs" subjected to unannounced drug testing.

c. **Probable Cause**: An employee may be tested for the presence of alcohol, psychoactive cannabis metabolites, and controlled substances listed in Appendix A-E of Chapter 67 of Title 9, Guam Code Annotated if their supervisor or Appointing Authority has credible reason to believe the employee is in possession of, has distributed, or is under the influence or impaired by drugs or alcohol while on duty or in the workplace, or worksite.

d. **Post-Accident:** drug testing (to include alcohol) conducted following incidents involving injuries, fatalities, transportation of hazardous materials, transportation of other employees, the public, or minors, or significant property damage.

e. **Follow-Up**: Drug testing (to include alcohol) during and/or upon completion of a rehabilitation program which will be conducted unannounced under direct observation.

f. **Retention of Re-employment Rights** (P.L. 38-4): classified employees occupying TDP positions who resign within 30 days of a departmental random drug test that they would have been subjected to must complete and clear said drug test prior to effective date of resignation in order to retain re-employment rights.

The drugs to be tested shall be for, but not limited to Cocaine, Opiates/Opioids (e.g. Heroin, Fentanyl), Phencyclidine (PCP), Amphetamines (e.g. methamphetamines), barbiturates and all controlled substances listed in appendix A-E of Chapter 67 of Title 9, Guam Code Annotated. Cannabis (marijuana) will also be tested (psychoactive metabolites of cannabis for most positions based on probable cause, post-accident and random testing, and non-psychoactive metabolites of cannabis for positions exempted under Section (d) or (e) of Public Law 37-119). Drug test results must indicate that the applicant/employee has passed their drug test consistent with U.S. drug testing industry standards such as the Department of Health and Human Services

DRUG-FREE WORKPLACE PROGRAM
GENERAL NOTICE FORM

Mandatory Guidelines for Federal Workplace Drug Testing Programs. Should Federal standards, or Guam laws and executive orders change at any time, DOA will conform its testing to the new standards.

All urine specimens undergo an initial screening to detect drugs and their metabolites. Should the initial screening detect drugs and their metabolites, a second screening shall be conducted utilizing Chromatograph-Mass Spectrometry (GC/MS) to confirm the presence of drugs and their metabolites. In the event your specimen test result is positive, you will be given the opportunity to discuss your test results with the Medical Review Officer (MRO) to establish your legitimate use of the specific drug(s) that was discovered during the urinalysis. However, should you dispute the MRO's report you may exercise your right to contest the drug test results as reported by the MRO. Should you choose to contest the MRO's report, you will have ten (10) business days from the date you were notified by the selecting agency to formally indicate in writing to the Human Resources Division (HRD), Department of Administration (DOA) that you dispute your drug test results. All cost associated with disputing the results reported by the MRO will be at your expense and proof of payment must be received by the HRD prior to any re-test or a secondary review of the same urine specimen. All drug test results will be handled in a confidential manner. Positive drug test results will only be disclosed to you by the Medical Review Officer, the Department of Administration and the hiring Appointing Authority.

Alcohol testing will be conducted based on probable cause, post-accident and follow up testing by trained personnel using a federally approved evidential breath alcohol measurement device.

Illegal or prohibited drug use to include alcohol will not be tolerated. Any employee who has a substance abuse problem is encouraged to seek assistance through their department/agencies Employee Assistance Program Counselor (EAPC). Such assistance may be obtained by contacting the EAPC or the Department of Administration. Should you voluntarily identify yourself to your supervisor or other appropriate management official as a user of illegal or prohibited drugs prior to being informed of a scheduled drug test, you may seek rehabilitation assistance. Should you qualify under the "**Safe Harbor"** provision you will not be subject to disciplinary action or dismissal, provided the terms of **"Safe Harbor"** conditions are being followed. Please note, under **"Safe Harbor"** this will be counted as a "First-Offense" and in the event you test positive for any drug test, are arrested for a drug-related offense, or refuse to take a drug test, you will be subjected to adverse action pursuant to the DFWP, the DOA Personnel Rules, and any applicable executive orders or laws. Should you be selected for or occupy a Testing Designated Position (TDP), you will be required to complete an Employee Individual TDP Notice Form and be advised that you will be subjected to random drug testing. Please note, employees occupying TDP positions are not eligible for "Safe Harbor" pursuant to 10 GCA Ch. 75, §75107.

Furthermore, if you as an employee in the classified service are arrested, charged by indictment, information or magistrate's complaint, or convicted of a drug related offense, you are to notify your department head in writing within seventy-two (72) hours thereof. Failure to provide such required notice is grounds for a separate adverse action pursuant to 4 GCA §4202.1, and §4202.2.

This is a General Notice to all employees that the Department of Administration will administer drug testing and refusal to submit to any required testing will result in discipline, up to and including dismissal. For more information, refer to the Drug-Free Workplace Policy which can be found on our website, **www.hr.doa.guam.gov**.

/s/ Director, Department of Administration

ATTACHMENT 15

Acknowledgement of General Notice of Drug-Free Workplace Program

I acknowledge that the Government of Guam promotes a Drug-Free Workplace Policy (DFWP). The DFWP is available for me to download on the Department of Administration's Human Resources Division's website: **www.hr.doa.guam.gov** under the "HR Branches – Drug Testing Branch" tab. I acknowledge receiving this General Notice and that failure to pass any required testing and refusal to submit to any required testing will result in discipline, up to and including dismissal.

Name of Employee: _____

Last four (4) digits of Social Security Number: _____

Department/Agency: _____

Signature: _____

Date: _____

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

ATTACHMENT 16

Acknowledgement of Family Medical Leave Act General Notice

By my signature below, I acknowledge receiving a copy of the Family Medical Leave Act (FMLA) Poster issued by the United States Department of Labor which serves as my FMLA General Notice.

Name of Employee: _____

Department/Agency: _____

Signature: _____

Date: _____

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

GOVERNMENT OF GUAM

DEPARTMENT OF ADMINISTRATION

HUMAN RESOURCES DIVISION

Revised December 1, 2025 **ATTACHMENT 17**

Employee Processing Form Checklist

Please initial alongside the space for which you filled out the appropriate documents

ATTACHMENTS	DOCUMENT NAME	INITIALS
1	Department Treasury Internal Revenue Service (Form W-4)	
2	Employment Eligibility Verification (I-9 Form) and List of Acceptable Documents	
3	Appointment Affidavits	
4	Designation of Survivor or Survivors (Unused Annual and Sick Leave Upon Death)	
5	Prior Service	
6	New Employee Master Data Form	
7	Group Term Life Insurance Program	
8	Medical and Dental Insurance Agreement	
9	Health Insurance Portability and Accountability Act (HIPAA)	
10	Acknowledgement of Insurance Premium Obligation While on Leave Without Pay Status	
10A	New Employee Processing Appointment Insurance Division Notice	
10B	New Employee Processing Appointment Insurance Division Slip	
11	Retirement Defined Contribution and Defined Benefit Plan-Questionnaire	
12	Retirement Defined Contribution and Defined Benefit Plan-Retirement Verification	
13	Report of Medical Examination-Retirement Copy	
14	Report of Medical Examination-Human Resources Division Copy	
15	Acknowledgement of General Notice of Drug Free Workplace Program	
16	Acknowledgement of Family Medical Leave Act General Notice	
17	Employee Processing Form Checklist	

I hereby certify that I have carefully reviewed and understand the attachments listed above, and that there were no missing attachments from the Employee Processing Form.

_____ _____

SIGNATURE WITNESS SIGNATURE

_____ _____

DATE DATE