



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



LOURDES A. LEON GUERRERO
Governor (Maga'hága)
JOSHUA F. TENORIO
Lt. Governor (Sigundo Maga'háhi)

WELCOME TO THE GOVERNMENT OF GUAM!

Dear New Employee,

Buenas yan Háfa 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		SOCIAL SECURITY NUMBER
LAST, FIRST, MI		
MAILING ADDRESS		DEPT / AGENCY
PO / ST NAME, CITY, STATE, ZIP		
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 (23456789)	0000000000	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:

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EMPLOYEE Signature / Date

BANK REPRESENTATIVE Signature / Date

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

Employee's Withholding Certificate

OMB No. 1545-0074

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.

2026**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.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.		

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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):		
	(a) Multiply the number of qualifying children under age 17 by \$2,000	3(a) \$	
	(b) Multiply the number of other dependents by \$500	3(b) \$	
	Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here	3	\$
Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here	4(b) \$	
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c) \$	

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet both of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 . . . ☐		
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 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 and you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. 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 16, 2027.

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 of tax withheld 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 (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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 5. 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 5 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 5 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 (plus any other additional amount you want withheld) **4** \$ _____

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.		
a Qualified tips. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000	1a \$	
b Qualified overtime compensation. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation	1b \$	
c Qualified passenger vehicle loan interest. If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000	1c \$	
2 Add lines 1a, 1b, and 1c. Enter the result here	2 \$	
3 Seniors age 65 or older. If your total income is less than \$75,000 (\$150,000 if married filing jointly):		
a Enter \$6,000 if you are age 65 or older before the end of the year	3a \$	
b Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment	3b \$	
4 Add lines 3a and 3b. Enter the result here	4 \$	
5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information	5 \$	
6 Itemized deductions. Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:		
a Medical and dental expenses. Enter expenses in excess of 7.5% (0.075) of your total income	6a \$	
b State and local taxes. If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately)	6b \$	
c Home mortgage interest. If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)	6c \$	
d Gifts to charities. Enter contributions in excess of 0.5% (0.005) of your total income	6d \$	
e Other itemized deductions. Enter the amount for other itemized deductions	6e \$	
7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here	7 \$	
8 Limitation on itemized deductions.		
a Enter your total income	8a \$	
b Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9	8b \$	
9 Enter: • \$768,700 if you're married filing jointly or a qualifying surviving spouse • \$640,600 if you're single or head of household • \$384,350 if you're married filing separately 	9 \$	
10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here	10 \$	
11 Standard deduction.		
Enter: • \$32,200 if you're married filing jointly or a qualifying surviving spouse • \$24,150 if you're head of household • \$16,100 if you're single or married filing separately 	11 \$	
12 Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly)	12 \$	
13 Add lines 11 and 12. Enter the result here	13 \$	
14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12	14 \$	
15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4	15 \$	

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	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190



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 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 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. 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		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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 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	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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 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.
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.
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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) Date (mm/dd/yyyy)	New Name (if applicable) 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) Date (mm/dd/yyyy)	New Name (if applicable) 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) Date (mm/dd/yyyy)	New Name (if applicable) 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.mct.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		TOTAL PRIOR SERVICE
		FROM	TO	
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		

Revised May 16, 2008

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

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008

ATTACHMENT 6

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

ACKNOWLEDGEMENT OF INSURANCE PREMIUM OBLIGATION WHILE ON LEAVE WITHOUT PAY STATUS (LWOP)

PRINT NAME	SSN/DOB	DATE OF HIRE

I certify that I understand my obligation to pay my health and life insurance premiums before going on Leave Without Pay (LWOP) status and that these payments must be made on a bi-weekly basis.

- **Health Insurance Obligation** — I am responsible for both the Government and subscriber portions of the medical and dental premiums for the duration of my LWOP. Payment must be made prior to entering LWOP to maintain active coverage. Failure to remit payment within 15 calendar days from the onset of LWOP will result in termination of coverage. Coverage will also be terminated for employees placed on Undetermined Status or Unauthorized Leave, retroactive to the last payment received. Re-enrollment or reinstatement will not be permitted until the next Open Enrollment Period and only after all outstanding obligations are fully satisfied.
- **Life Insurance Obligation** — I am responsible for paying premiums for any supplemental and/or dependent life insurance coverage. The Government of Guam will continue contributing its share of the basic life insurance premium 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 am responsible to pay back the government's contribution for my insurance. Failure to remit premiums will result in termination of coverage.

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.

For LWOP payments, I will contact the Department of Administration, Division of Accounts, at 671-477-5861 or 475-1166 to obtain a payment receipt and submit payment to the Treasurer of Guam. I will provide a copy of the receipt to the Department of Administration, Insurance Division. I understand that failure to make required payments will result in termination of my health and life insurance coverage due to non-payment.

EMPLOYEE'S SIGNATURE

DATE

WITNESS (Insurance Division Only)

DATE

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	DESCRIPTION OF ABNORMALITY
23. HEAD, FACE SCALP				
24. NOSE, MOUTH, THROAT				
25. EARS				
26. EYES – GENERAL				
27. OPHTHALMOSCOPIC				
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: <u>Only if indicated</u>					
a. CBC (No Differential)		d. Hemocult		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 <u>NOT</u> 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	DESCRIPTION OF ABNORMALITY
23. HEAD, FACE SCALP				
24. NOSE, MOUTH, THROAT				
25. EARS				
26. EYES - GENERAL				
27. OPHTHALMOSCOPIC				
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: <u>Only if indicated</u>			
a. CBC (No Differential)	d. Hemocult	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 <u>NOT</u> 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



DRUG-FREE WORKPLACE PROGRAM GENERAL NOTICE FORM



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:

10 10 10 10

10 10

10 10 10 10

10 10

**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