DEPARTMENT OF EDUCATION
Leave Application Form

Employee Name (Print) :	School/Division:	Location Code:

Employee ID No. 690-0	Job Code:	PPE Date:	Total No. Hours

PHYSICAL ADDRESS WHILE ON LEAVE: (Check [√] One and Write Address)

☐ ON ISLAND: ☐ OFF-ISLAND:

LEAVE DATE (S)		LEAVE HOURS/TIME		Leave Type		
From (Start)	To (End)	From	To	# of Hours	# of Days	"Please check [√] and select one (1) per row."
						[ ] Sick [ ] Annual [ ] Personal [ ] LWOP [ ] Other (Please Specify)
						[ ] Sick [ ] Annual [ ] Personal [ ] LWOP [ ] Other (Please Specify)
						[ ] Sick [ ] Annual [ ] Personal [ ] LWOP [ ] Other (Please Specify)
						[ ] Sick [ ] Annual [ ] Personal [ ] LWOP [ ] Other (Please Specify)

APPLICATION FOR PREPAYMENT OF VACATION LEAVE

MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) CONSECUTIVE WORKDAYS. IT IS UNDERSTOOD THAT IF I RETURN TO DUTY BEFORE THE EXPIRATION OF MY PREPAID VACATION, I SHALL REIMBURSE THE GOVERNMENT OF GUAM IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.

From (HOUR, Month, Day, Year)	To (HOUR, Month, Day, Year)	TOTAL No. of Hours Prepaid

I CERTIFY THAT THE ABOVE NAMED PERSON WAS UNDER MY PROFESSIONAL CARE OR QUARANTINED DURING THE PERIOD STATE BELOW, FROM A MEDICAL STANDPOINT. HIS/HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE TO REPORT FOR WORK.

From (Month, Day, Year)	To (Month, Day, Year)	Hospitalized [ ] YES [ ] NO	No. of Day(s)

REMARKS:

NAME OF PHYSICIAN (Print or Type)	(Signature of Physician) Date Signed:
Signature of Employee:	Date of Request:
[ ] APPROVED [ ] DISAPPROVED	(Signature of Supervisor) Date Signed:
[ ] APPROVED [ ] DISAPPROVED	(Signature of Appointing Authority or Authorized Designee) Date Signed:

Administrator's Comments:

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