



NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:			
Scott T. Mendiola	97547				
<u></u>	97547	March 31, 2015			
TYPE OF LEAVE REQUESTED:					
SICK X ANNUAL MAT	FERNIT EDUCATION	NA MILITARY JURY OTHER			
PAY STATUS:	HOURS:	(24) 4-2-150			
X W/PAY W/O PAY COMBI	NATION W/PAY	W/OUT PAND			
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR	R):			
April 01, 2015	April 18, 2015 Ap	ri / 03, 2015 (A) Charge Account NO:			
ADDRESS WHILE ON LEAVE:					
ADDRESS WHILE ON LEAVE:	Chalan F	200			
	Criatur 1	ago			
	APPLICATION FOR PREPA	YENT OF VACATION LEAVE			
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10 THE EXPIRATION OF MY PREPAID VACATION, I SHAL	) CONSECUTIVE WORKING DAYS, IT IS	SUNDERSTOOD THAT IS I PETITION TO CUTTY RESOUR			
PORTION OF THE PREPAID LEAVE.	INDINIONAL THE GOACHAMENT IN	NAMOUNT EQUIVALENT TO THE UNEXPIRED			
	SICK I FAVE (	CERTIFICATION			
IN COMPLIANCE WITH PERSONNEL RULES AND REG	ULATIONS, GOVERNMENT OF GUAM I	F ANY EMPLOYED IS ARREST DECAUSE OF			
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF T A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO	HREE CONSECUTIVE WORKING DAYS, BE GRANTED SICK I FAVE THE COVER	OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER			
PURNISH A CERTIFICATION AS TO THE INCAPACITY	FROM A REGULAR LICENSED PHYSIC!	AN THE DEPARTMENT HEAD MAY BEGINDE			
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNE ABSENCE WHICH WOULD HAVE BEEN COVERED BY	SS HE DEEMS ADVISABLE, IF THE CENTER SUCH CERTIFICATION SHALL BE INDICATED AND ADVISABLE.	RTIFICATION REQUIRED IS NOT FURNISHED, ALL			
MITTOG PAT. SICK LEAVE PORTION FOR TRIVIAL	NDISPOSITION, OR FALSIFICATION OF	AN ILLNESS REPORT SHALL BE CONSIDERED			
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOV I CERTIFY THAT THE ABOVE NAMED PERSON WAS I	ERNMENT SERVICE.  JNDER MY PROFESSIONAL CARE OF 1	NIADANTINED DUDING THE BERIOD STATES			
BELOW: FROM A MEDICAL STANDPOINT, HIS OR HE FROM HIS OR HER TO REPORT TO WORK.	R CONDITION DURING THIS PERIOD W	AS SUCH THAT I CONSIDERED IT INADVISABLE			
FROM (MONTH, DAY, YEAR): TO (MONTI	H, DAY, YEAR): HOSPITAL	ZED? NUMBER OF DAYS:			
	YE	s No			
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN			
REMARKS:					
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)					
APPROVED [N/]					
YES NO	C	SIGNATURE OF SUPERVISOR) Dames			
APPROVED YES NO	SIGNATURE OF APPOINTING AUTH	HORITY OR AUTHORIZED DELEGATE)			
		İ			



# I LIHESLATURAN GUÅHAN GUAM LEGISLATURE 155 Hesler Place, Hagatna, Guam 96910

### LESCHHAET WAAROTT OLIGH ENVINTERENZATION

MAY 12,2015

NAME (FIRST	, MIDDLE, LAST	):	PAYROL	I NO ·	· · ·	IDATE F	EQUESTED:		· · · · · · · · · · · · · · · · · · ·		
	,		1	.L 11O		DATER	EQUESTED:				
1/2100	AD Pa	Livo					1		<i>d</i> .		
TYPE OF LEA	VE DECLIESTED	WIND	<u> </u>		<del></del> .	111	AY 11	1, 12	£ 13,	20/5	<b>*</b>
	VE TIEGOESTEL	,. 								<u></u>	
SICK	ANNUAL	MA <sup>-</sup>	FERNITY		EDUCATIO	NAL	MILIT.	ARY	JURY		OTHER
PAY STATUS				HOURS:				7 -	1.1.6	<u> </u>	<del> </del>
W/PAY	W/O PAY	СОМВ	INATION		W/PAY	24 A	W/OU	TPAY	DCD)		
FROM (HOUR	, MONTH, DAY, `	/EAR):	TO (HOU	R, MONTH	, DAY, YEA		· · · · · · · · · · · · · · · · · · ·	<del></del>	Ta: -		
1:00pm	MAY 11.	20/5	5am	MAS	11,295		4 hes		Charge Accoun	nt NO:	
8:00 pm	May 12	,2015	\$ our	may	12,20/5		Phas	· · ·		·	
8:00 pm	Mby 12	2015	Son	20/4	12 200		600		<del> </del>	<del>-</del>	<del> </del>
	ILE ON LEAVE!		10/11	ming	13/293	<u> </u>	//KS		<u></u>		· · · · · · · · · · · · · · · · · · ·
1	•	143 1	9B .	Wond	24H	/\k.	Agara	HE	ights		
								:: :::::::::::::::::::::::::::::::::::	1,000		tana kanakan
MINIMUM REQUIS	EMENT IS NOT LES	C TUAN TEN (4)	AF	PLICATION	FOR PREPA	YENT OF	ACATION LEA	WE			
THE EXPIRATION	EMENT IS NOT LES	S THAN TEN (10 CATION, I SHAL	I) CONSECUT L REIMBURS	FIVE WORKING	IG DAYS, IT IS RNMENT IN A	UNDERSTO	OD THAT IF I RE	TURN TO DU	TY BEFORE	·	
PORTION OF THE	PREPAID LEAVE.					-	-GOIVALEIVI (O	THE UNEXP	IHED		
					IOV I FAVE						
IN COMPLIANCE V	VITH PERSONNEL A	ULES AND REG	ULATIONS, G	OVERNMEN	T OF GUAM, IF	ANY EMPL	TYPE IS ABSENT	T BECAUSE C			
ILLNESS, INJURY,	OR QUARANTINE IN	I EXCESS OF TI	REE CONSE	<b>CUTIVE</b> WO	RKING DAYS:	OR FOR THE	DAY IMMEDIAT	ELV DECODE	OD ACTED		
FURNISH A CERTI	END, DAY OFF, OR FICATION AS TO TH	VACATION, TO	BE GRANTED FROM A DEC	SICK LEAVE	THE GOVER	NMENT EMP	LOYEE SHALL B	E REQUIRED	то		
CERTIFICATION F	OR SUCH OTHER PE	RIOD OF ILLNE	SS HE DEEM	IS ADVISABL	E. IF THE CER	TIFICATION	RECITIONED IS AL	OT ELIDNICH	ED ALI		
ABSENCE WHICH	WOULD HAVE BEEN	COVERED BY	SUCH CERTII	FICATION SH	IALL BE INDIC.	TED ON TH	E PAVDOLL AC	ENVE OF A	OFNOR		
WITHOUT PAT. S	CK LEAVE PORTION E FOR DISMISSAL F	FOR TRIVIAL I	NDISPOSITIO	N, OR FALSI	FICATION OF	AN ILLNESS	REPORT SHALL	BE CONSIDE	RED		
I CERTIFY THAT T	HE ABOVE NAMED F	ERSON WAS L	NDER MY PE	OFESSIONA	L CARE OR Q	JARANTINE	D DURING THE I	PERIOD STAT	ren		<del></del>
BELOW. FROM A	MEDICAL STANDPO	INT, HIS OR HE	R CONDITION	N DURING TH	IS PERIOD WA	s such th	AT I CONSIDERE	ED IT INADVIS	BABLE		İ
FROM (MONTH		TO (MONT	H, DAY, YE	AR):	HOSPITAL	IZED?	·	NUMBER	OE DAVS:	<del></del>	
				]	l			NONDEN	OI DAIG.		
					L	:S	NO				
NAME OF PHY	SICIAN (PRINT C	R TYPE)		·		SIGNATU	RE OF PHYS	ICIAN	<del>"</del>	<del></del>	
REMARKS:											
<del></del>	<u> </u>										
CERTIFY ALL STA	TEMENTS MADE HE	REIN ARE TRU	E AND CORR	ECT		(SIGNATURI	OF EMPLOYEE	)	×		
APPROVED [	YES	NO								·	
L	<u>▼</u> 1E9	NO				(SIGNATUBL	OF SUPERVISO	OR)			
						(	alow	KA >	ı		j
APPROVED [	VES	NO NO	SIGNATUR	E OF APPOI	NTING AUTH	ORITY OR	AUTH PRIZED	DELEGATE)	)		
L		"	<i>` N</i> I.∕	Sh			<b>\</b>				
			/ /W	MAR							
			And	<i>Y</i>	•						ĺ

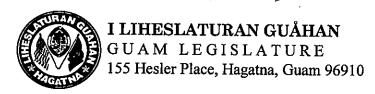


# I LIHESLATURAN GUÅHAN GUAM LEGISLATURE 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATION

MAY 12 2015
11:55 91:20 May 1 17:33
3ECEIVE W. DO

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:		
1.1.1.2.1				
TYPE OF LEAVE REQUESTED:		MAY 11.	2%s	
				· · · · · · · · · · · · · · · · · · ·
SICK ANNUAL MAT	ERNITY EDUCATION	DNAL MILITARY	JURY	OTHER
PAY STATUS:	HOURS:	-1-15-	<del></del>	
W/PAY W/O PAY COMB	NATION W/PAY	W/OUT PAY		
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YE	(00)		
8 AM MAY 06, 2015	5pm May 06, 20		Charge Account N	10:
1 pm May 07 2015	5 pm MAY07,29			
Gam may 14, 2015	5pm may 14,20	15 8 hrs		
ADDRESS WHILE ON LEAVE:	<del>- ( - 29) .   2</del>			
143 AB Wonpat 1	Dr. Afana 1	teights		
	APPLICATION FOR PREF	AYENT OF VACATION LEAVE		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) THE EXPIRATION OF MY PREPAID VACATION ASHAU	I CONSECUTIVE WORKING DAVE IT I	C LIMPEDCTOOD THE PARTY	O DUTY BEFORE	
THE EXPIRATION OF MY PREPAID VACATION, I SHALL PORTION OF THE PREPAID LEAVE.	- HEIMBURSE THE GOVERNMENT IN	AN AMOUNT EQUIVALENT TO THE U	NEXPIRED	
	SICK I EAVE	CERTIFICATION		
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATION OF CHARANTINE IN EXCESS OF THE	JEATIONS GOVERNMENT OF CHAM	CERTIFICATION  IF ANY EMPLOYEE IS ABSENT BECA	USE OF	
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO E	HEE CONSECUTIVE WORKING DAYS HE GRANTED SICK LEAVE THE COVE	OR FOR THE DAY IMMEDIATELY BE	FORE OR AFTER	i
THE INCAPACITY F	HOM A REGULAR LICENSED DUVEICI	AM THE DEDARGEMENT OF A		
ABSENCE WHICH WOULD HAVE BEEN COVERED BY	SUCH CERTIFICATION SHALL BE INDIC	RTIFICATION REQUIRED IS NOT FUR	NISHED, ALL	
THE PROPERTY OF THE PROPERTY O	IDISPOSITION. OR FALSIFICATION OF	AN ILLNESS REPORT SHALL BE CO	OF ABSENCE NSIDERED	
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE CERTIFY THAT THE ABOVE NAMED PERSON WAS U	HAMENT SERVICE			
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HEF FROM HIS OR HER TO REPORT TO WORK.	CONDITION DURING THIS PERIOD W	AS SUCH THAT I CONSIDERED IT IN	STATED ADVISABLE	
THE THE PORT TO WORK,	H, DAY, YEAR): HOSPITA			
			BER OF DAYS:	
		ES NO		
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN		
REMARKS:				
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE	AND CORRECT	(SIGNATURE OF EMPLOYEE)		
PPROVED YES NO			110	
		(SIGNATURE OF SUPERVISOR)	4/2	
PPROVED YES NO (S	IGNATURE OF APPOINTING AUTI	HORITY OR AUTHORIZED DELEG	ATE	
		$A \subset A$	1	
		Y/ /		
		1		
		V		



NOV 25 2015

Hans: 1005 X

RECEIVED 8V. 20000

क्षेत्रकाराः क्ष्मकाराज्ञे स्टब्स्स्य । १ जनामनुक्षम् । १५ ४ वर्षः १५ ४

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED		·
		Jr.	•	
JERMAINIE ALERTA		11/23/15		
TYPE OF LEAVE REQUESTED:			<del></del>	
SICK ANNUAL MA	TERNITY EDUCATION	ONAL MILIT	FARY JURY	OTHER
PAY STATUS:	HOURS:	~040M	· · · · · · · · · · · · · · · · · · ·	-
	INATION W/PAY		JT PAY	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEA	R):	Charge Account N	10·
11.00 AM 11/8/15	12:Wpm 11/94/1	<u>স</u>		10.
	, , , , , , , , , , , , , , , , , , ,	<u> </u>		
				<del>-</del>
ADDRESS WHILE ON LEAVE:				<del></del>
Hagatna Qu				
	APPLICATION FOR PREPA	AVENT OF VACATION LE	A ber	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10)	CONSECUTIVE WORKING DAYS, IT IS	UNDERSTOOD THAT IF LE	ETHEN TO DUTY DECODE	·-
THE EXPIRATION OF MY PREPAID VACATION, I SHALL PORTION OF THE PREPAID LEAVE.	. REIMBURSE THE GOVERNMENT IN A	IN AMOUNT EQUIVALENT TO	O THE UNEXPIRED	
IN COMPLIANCE WITH PERSONNEL RULES AND REGL	JLATIONS, GOVERNMENT OF GUAM, I	CERTIFICATION  F ANY EMPLOYEE IS ABSEN	IT BECALISE OC	
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TH	REE CONSECUTIVE WORKING DAYS.	OR FOR THE DAY IMMEDIA:	TELV BECODE OD ACTED	
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO B FURNISH A CERTIFICATION AS TO THE INCAPACITY F	BE GRANTED SICK LEAVE THE GOVER	NMENT EMPLOYEE SHALL I	RE DECLIDED TO	
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES	SS HE DEEMS ADVISABLE. IF THE CER	STIFICATION REQUIRED IS N	IOT ELIDADOLICIO ALL	
ABSENCE WHICH WOULD HAVE BEEN COVERED BY S WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL IN	UCH CERTIFICATION SHALL BE INDIC	ATED ON THE PAVEOUS AS	LEAVE OF AGCENCE	
SUPPLICIENT CAUSE FOR DISMISSAL FROM THE GOVE	RNMENT SERVICE.			
CERTIFY THAT THE ABOVE NAMED PERSON WAS UNBELOW. FROM A MEDICAL STANDPOINT, HIS OR HER	IDER MY PROFESSIONAL CARE OR O	WARANTINED DURING THE	PERIOD STATED	<u> </u>
NOM HIS ON HER TO REPORT TO WORK.			ED IT INADVISABLE	
FROM (MONTH, DAY, YEAR): TO (MONTH	I, DAY, YEAR): HOSPITAL	LIZED?	NUMBER OF DAYS:	<del></del>
		ES NO		
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYS	BICIAN	<del></del>
REMARKS:	<del></del>			
				<del> </del>
				<del></del>
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE	AND CORRECT	(SIGNATURE OF EMPLOYE	DAP-	
PPROVED YES NO	· · · · · · · · · · · · · · · · · · ·		A A 30	
		(SIGNATURE OF SUPERVIS	7010	<b>1</b>
PPROVED YES NO	SIGNATURE OF APPOINTING AUTH	ORITY OR AUTHORIZED	DELEGATE)	
				İ
			_	



# I LIHESLATURAN GUĂHAN GUAM LEGISLATURE 155 Hesler Place, Hagatna, Guam 96910



SEP 30 2015

·	LEAV	/E FORM -	
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:	
Tina Rose Alicto	panne	September 24, 2015	
TYPE OF LEAVE REQUESTED:			
SICK X ANNUAL MAT	ERNITY EDUCATION	DNAL MILITARY	JURY OTHER
PAY STATUS:	HOURS:	CARDO AS	0.75
	NATION W/PAY	W/OUT PAY_	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEA	AR):	Charge Account NO:
9/28/15; 8am	9/30/15; 5:00pm	Return on Thursday 10/1/15	993
			<del></del>
ADDRESS WHILE ON LEAVE:	Manailes O		
	Mangilao Guam		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10)	CONSECUTIVE WORKING DAYS IT	AYENT OF VACATION LEAVE	
THE EXPIRATION OF MY PREPAID VACATION, I SHALL PORTION OF THE PREPAID LEAVE.	REIMBURSE THE GOVERNMENT IN A	S UNDERSTOOD THAT IF I RETURN TO DI AN AMOUNT EQUIVALENT TO THE UNEXF	UTY BEFORE
OTHIONOF THE PHEPAID LEAVE.			
	CICKLENIE		
N COMPLIANCE WITH PERSONNEL RULES AND REGULLNESS, INJURY, OR QUARANTINE IN EXCESS OF THE	LATIONS GOVERNMENT OF CULL !	C 44194 C1454 C145	OF
FURNISH A CERTIFICATION AS TO THE INCAPACITY F	BOM A REGULAR LICENSED BUNGLO	INMENT EMPLOYEE SHALL BE REQUIRED	ото
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE	BIMENT SERVICE	AN ILLNESS REPORT SHALL BE CONSID	ÉRED
CERTIFY THAT THE ABOVE NAMED PERSON WAS UK	DER MY PROFESSIONAL CARE OF	UARANTINED DURING THE PERIOD STA	TED
ROM HIS OR HER TO REPORT TO WORK.	CONDITION DURING THIS PERIOD W	AS SUCH THAT I CONSIDERED IT INADVI	SABLE
	I, DAY, YEAR): HOSPITAL	IZED? NUMBER	OE DAVO:
	7 1 -		OF DAYS:
	L   Y	ES NO	
IAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
CARADICO.			
EMARKS:			
ERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE	AND CORRECT	(SIGNATURE OF EMPLOYEEY)	<del></del>
	<b>`</b>	My My Cour	1)
PPROVED YES NO		(SIGNITURE (FLAT PERVISOR)	
PPROVED (S	IGNATURE OF APPOINTING AND	Ann	
YES NO	ACPOINTING AUTH	HORITY OR AUTHORIZED DELEGATE	=)
<del></del>			1
			1



# I LIHESLATURAN GUÄHAN GUAM LEGISLATURE 155 Hesler Place, Hagatna, Guam 96910

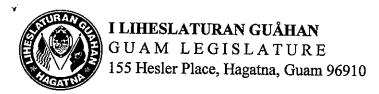
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:	<del></del>
Tina Rose Alicto	namma	}	
	097714	November 5, 2015	
TYPE OF LEAVE REQUESTED:		· · · · · · · · · · · · · · · · · · ·	
SICK ANNUAL MAT	ERNITY EDUCATION	NAL MILITARY	JURY OTHER
PAY STATUS:	HOURS:	CANAN .	
W/PAY W/O PAY COMBII	NATION W/PAY	WOUT PAY_	
	TO (HOUR, MONTH, DAY, YEAR	R):	Charge Account NO:
Nov 5, 15; 2:00pm	100 5, 15,5 Wpr	h	onarge Account 140.
Par 6, 13; 8:00 am	NOV 6, 15,5,00.	om	
ADDRESS WHILE ON LEAVE: Mangilao	Guam		
	APPLICATION FOR PREPA	VENT OF VACATION LEAVE	<del></del>
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) THE EXPIRATION OF MY PREPAID VACATION, I SHALL	CONSECUTIVE WORKING DAYS, IT IS	UNDERSTOOD THAT IS LIBETURE TO F	DUTY BEFORE
PORTION OF THE PREPAID LEAVE.			
<del></del>	SICK LEAVE C	ERTIFICATION	
IN COMPLIANCE WITH PERSONNEL RULES AND REGU	ILATIONS, GOVERNMENT OF GUAM, IF	ANY EMPLOYEE IS ABSENT DECAUSE	OF
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THE A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO B	E GRANTED SICK LEAVE THE GOVERN	MENT EMPLOYEE SHALL BE DECUME	ED TO
ILOHNISH A CERTIFICATION AS TO THE INCAPACITY E	ROM A REGULAR LICENSED PHYSICIAI	N THE DEPARTMENT HEAD MAY BEGI	nor
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES ABSENCE WHICH WOULD HAVE BEEN COVERED BY S	UCH CERTIFICATION SHALL BE INDICA	TED ON THE PAYDOLL ACTIONS OF	ADODNOT
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL IN SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE	DISPOSITION, OR FALSIFICATION OF A	AN ILLNESS REPORT SHALL BE CONSI	DERED
I CERTIFY THAT THE ABOVE NAMED PERSON WAS UN	DER MY PROFESSIONAL CARE OR OL	JARANTINED DURING THE PERIOD ST.	ATED
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER FROM HIS OR HER TO REPORT TO WORK.	CONDITION DURING THIS PERIOD WA	S SUCH THAT I CONSIDERED IT INAD	/ISABLE
FROM (MONTH, DAY, YEAR): TO (MONTH	I, DAY, YEAR): HOSPITAL	IZED? NUMBEF	OF DAYS:
	YE	s No	
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
		SIGNATURE OF PHTSICIAN	
REMARKS:			
		<del> </del>	
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE		<u> </u>	0
APPROVED APPROVED	AND CONNECT (	SIGNAZURE OF EMPLOYEE)	Mid
YES NO		SIGNATURE OF SUPERVISORS	de
APPROVED YES NO (S	IGNATURE OF APPOINTING AUTH	ORITY OR AUTHORIZED DELEGA	TE)
	Alta_	_	



# I LIHESLATURAN GUÅHAN GUAM LEGISLATURE 155 Hesler Place, Hagatna, Guam 96910

# GUAN LEGISLATIPE PERSONNA MARROLL OFFICE

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.	:	DATE REQUES	STED:	<u> </u>
PINCH	9762	a			•
Tatrick S. Alvarez  TYPE OF LEAVE REQUESTED:	9752	<u>. 7</u>	1-20.	-13	
	_	·			СТО
	ATERNITY _	EDUCATION	IAL	MILITARY JU	RY OTHER
PAY STATUS:	но	URS:	1-29	2-14	8am - Spm 1-20-15 -
W/PAY W/O PAY COME	BINATION	W/PAY	32)hrs.	WOUT PAY	Bam-Spm 1-21-15 7
FROM (HOUR, MONTH, DAY, YEAR):	TO CHOUR MO:	NTH, DAY, YEAR)			1-23-15 S
	1	_	, CH	ARGE ACCOUNT NO.:	<u> </u>
8am 1-20-15	Spm	1-23-15			
ADDRESS WHILE ON LEAVE:	<u> </u>	<u> </u>			
Chalan Tun Ben A	Anaco S	H. Yian	96929		
		<u></u>			
ANIMUM REQUIREMENT IS NOT LESS THAN TEN (1	<ul> <li>O) CONSECUTIVE WO</li> </ul>	TION FOR PREPATORKING DAYS, IT IS U	MINER CTOOPS THE ATTER	THE T PRINCIPLE AND ADDRESS OF THE PARTY OF	
HE EXPIRATION OF MY PREPAID VACATION, I SHA ORTION OF THE PREPAID LEAVE.	LL REIMBURSE THE	GOVERNMENT IN AN	AMOUNT EQUIVAL	ENT TO THE UNEXPIRED	
COMPLIANCE HAVE DEPRODUCED BY		SICK LEAVE C	ERTIFICATION		
COMPLIANCE WITH PERSONNEL RULES AND REG LNESS, INJURY, OR QUARANTINE IN EXCESS OF TH HOLIDAY WEEKEND, DAY OFE OR VACATION, TO	ULATIONS, GOVERNI	MENT OF GUAM, IF A	NY EMPLOYEE IS A	BSENT BECAUSE OF	
The state of the s	DE UKANTED SICK I	HAVE THE COVERNA	CATTY OF OVER BY	7177	[.
design continuous to the month citi	LKUMA KHIJIJAR I I	ICHNODO BEIVETOLAX	TITLE TAYED A TARE OF THE		
WEST TON TON TON BUCK OTHER PERSON OF HIT WEST	SS HE DEEMS ADVISA	ANTE TETTE PER TINA	CATTONITOTOTOTOTO	70 1 20 m man	
SENCE WHICH WOULD HAVE BEEN COVERED BY ITHOUT PAY, SICK LEAVE PORTION FOR TRIVIAL INFICIENT CAUSE FOR DYSMISSAY ERONG THE COUR	TAMES CONTINUE OF I	N SHALL BE INDICAT FALSIFICATION OF A	ED ON THE PAYRO N II I MESS DEBODE:	LL AS LEAVE OF ABSENCE	
THE GOAL LOW DISHERS IN LY ON THE GOAL	EKNMENT SERVICE				}
ERTIFY THAT THE ABOVE NAMED PERSON WAS LOW. FROM A MEDICAL STANDPOINT, HIS OR I COM HIS OR HER TO REPORT TO WORK.	HER CONDITION OF	SSIONAL CARE OR	QUARANTINED DU	RING THE PERIOD STATED	
		THE THIS PERIOD	WAS SUCH THAT I	CONSIDERED IT INADVISABLE	ļ
COM (MONTH, DAY, YEAR): TO (MONTH	L DAY, YEAR):	HOSPITALIZ	ED?	NUMBER OF DAYS:	·
		YES	NO NO		
IME OF PHYSICIAN (PRINT OR TYPE)	<del></del>	S	GNATURE OF P	HYSICIAN	
MARKS:					
				7	
	_	J			
ertify all statements made herein are ti	RUE AND CORRECT	(SI	GNATURE OF EMP	OVEE)_	· .j
			XI		
PROVED YES NO			\\		
I ILS NO		(SI	GNATURE OF SUPER	LYISOR)	
PROVED (S	IGNATURE OF APP	OINTING AUTHOR	TY OR AUTHORI2	YED DELEGATIO	
YES NO	Λ	1			
	. 9km	الم	_		
	Con-mo	J. Mu	7 ·		
			<u> </u>		<del></del>

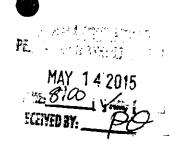


# SCOCUNNEL IDSABULT ULLICE

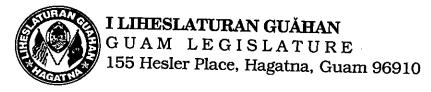
AUG 192015 .mc; 900 x am; 1 1 PM ECEIVED BY: 000

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:	
1, 1,		_	
TYPE OF LEAVE REQUESTED:	897865	1406	18,2015
	<u> </u>		
	TERNITY EDUCATIO	NAL MILITARY	JURY OTHER
PAY STATL P	HOURS:	(20) MARY	19.15
W/PAY W/O PAY COMB	INATION W/PAY	W/OUT PA	1 <u>v</u> —
	TO (HOUR, MONTH, DAY, YEAR	₹):	Charge Account NO:
from ALE 19, 2015	5 pm /2921, 2016		Onding Account NO.
ļ			
ADDRESS WHILE ON LEAVE:			
	ut, Branghoo	, Ontorio, Co	uda L642L2
	APPLICATION FOR PREPA	VENT OF VACATION LEAVE	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10 THE EXPIRATION OF MY PREPAID VACATION, I SHAL PORTION OF THE PREPAID LEAVE.	)) CONSECUTIVE WORKING DAYS IT I	STINDEDSTOOD THAT IS LIGHT	11511 70 61 71 71 71
	SICK LEAVE C	EDTIFICATION	
IN COMPLIANCE WITH PERSONNEL RULES AND REG	ULATIONS, GOVERNMENT OF GUAM	IE ANY ENDLOYEE IS A DOCUME	BECAUSE OF
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THE A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO THE INJURY A CERTIFICATION AS TO THE MAN AS TO TH	TREE CONSECUTIVE WORKING DAVE	OR FOR THE DAY HAVE OUTE	11/5==0==
I DIGHOLLY CERTIFICATION NO TO THE INCAPACITY	FROM A REGULAR LICENSED DHYSICI	AM THE DEDARTMENT HEAD.	3333 Mm = 1 11 = -
ABSENCE WHICH WOULD HAVE BEEN COVERED BY:	SS HE DEEMS ADVISABLE. IF THE CE SUCH CERTIFICATION SHALL BE INDIC	RTIFICATION REQUIRED IS NO	T FURNISHED, ALL
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL II SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOV	NUISPOSITION. OR FAI SIFICATION OF	AN ILLNESS REPORT SHALL	BE CONSIDERED
I CERTIFY THAT THE ABOVE NAMED PERSON WAS U	NDER MY PROFESSIONAL CARE OR	QUARANTINED DURING THE PI	FRIOD STATED
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HE FROM HIS OR HER TO REPORT TO WORK.	R CONDITION DURING THIS PERIOD W	AS SUCH THAT I CONSIDERED	OT INADVISABLE
	I, DAY, YEAR): HOSPITALI	ZED? NUI	MBER OF DAYS:
	YES	S NO	
NAME OF PHYSICIAN (PRINT OR TYPE)		GIGNATURE OF PHYSICIA	N
	١	MONTONE OF PHIOLOGR	NA CONTRACTOR OF THE CONTRACTO
REMARKS:	· · · · · · · · · · · · · · · · · · ·	<del></del>	
			0. 0.4
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUI	E AND CORRECT (S	IGNATURE OF MPLOYEE)	elle Godfra
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	MAPEGYEE)	J
APPROVED YES NO			0 = 0
	(S	IGNATURE OF SUPERVISOR)	regain
PPROVED YES NO (SI	GNATURE OF APPOINTING AUTHO	DRITY OR AUTHORIZED DE	LEGATE)
	A		
	Fil-		
	/		





	1					
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	ĮD,	ATE REQUESTED:			
	97746		~/6/1cm	•		
127 - + 10 1011 2000		'	77.			
VIRGINIO F. AR PILLEDA TYPE OF LEAVE REQUESTED:	<u> </u>					
TYPE OF LEAVE REQUESTED:					CTO -	
SICK NAME OF THE				ADV	V STUTE	
SICK X ANNUAL MA	TERNITY ED	DUCATIONA	L MILIT	ARY JUR	Y X OTHER	
PAY STATUS:	HOURS:		5-14-	<u>(</u> S	(O CTO	
W/PAY W/O PAY COME	NATION	(	مري (رازا	<b>,</b> ,	0 0.0	
W/PAT   W/O PAY   COME	BINATION W	//PAY _	YU JOHN	T PAY	34 Annual	
<del></del>		,				
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, D	AY YEAR):		101		
l <b>.</b> ' ' ' ' ' ' ' ' ' ' ' '	l ' ' . ' '	•		Charge Ad	count NO:	
8am 5-11-15	5pm Mai	4 15,12	015			
	<b>1</b>	3				
ADDRESS WHILE ON LEAVE:						
# 12 SAPYMANOK	ST. LACOL	INA	YILLAGE	F METRO	MANILA	
		55 V, 85 W	Paris Control (Assert Paris	TO BE WANTED TO THE TO SEE AND ADDRESS.		
	APPLICATION FO	R PREPAYE	NT OF VACATION L	EAVE		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (1	(0) CONSECUTIVE WORKING	G DAYS, IT IS	UNDERSTOOD THAT IF	I RETURN TO DUTY BEFO	RE	
THE EXPIRATION OF MY PREPAID VACATION, I SHA	LL REIMBURSE THE GOVER	ANMENT IN AN	I AMOUNT EQUIVALEN	T TO THE UNEXPIRED		
PORTION OF THE PREPAID LEAVE.						
	The second of the second					
			RTIFICATION	· · · ·		
IN COMPLIANCE WITH PERSONNEL RULES AND RE						
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF					iR .	
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO						
FURNISH A CERTIFICATION AS TO THE INCAPACITY						
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLN ABSENCE WHICH WOULD HAVE BEEN COVERED BY						
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL						
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GO		IOATION OF A	NA IEDAEGO MELONI SI	TALL DE CONSIDERED		
I CERTIFY THAT THE ABOVE NAMED PERSON WAS		CARE OR O	IARANTINED DURING	THE PERIOD STATED		
BELOW. FROM A MEDICAL STANDPOINT, HIS OR H						
FROM HIS OR HER TO REPORT TO WORK.						
FROM (MONTH, DAY, YEAR): TO (MONT	TH, DAY, YEAR):	OSPITALIZ	ED?	NUMBER OF DAYS:		
		YES	NO NO			
NAME OF PHYSICIAN (PRINT OR TYPE)		SI	GNATURE OF PHY	SICIAN		
REMARKS:						
TILIPATINO.						
					<u> </u>	
				• , ,	0 24 0	
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE) Ungalate To Carpello de						
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TR	TOE AND CORRECT	l(S)	GNATURE OF EMPLOY	EE) UMTRICE	nage	
/						
APPROVED -				<del></del>		
YES NO				$\wedge$		
<del></del>		(SI	GNATURE OF SUPERVI	ISOR)/		
				Y 11 1		
APPROVED -	(SIGNATURE OF APPOIN	ITING AUTHO	ORITY OR AUTHORIZ	ED DELEGATE		
YES NO						
				UT T		
				/ / / )		
				' //		

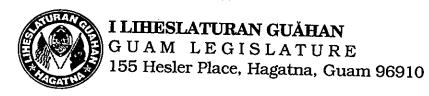


BENDAMEN STATES

JUNE 1 1 2015

T.ME. 1140 | TAME !

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE DESCRIPTION	
· ·	AMOLE NO.:	DATE REQUESTED:	
Vincent P. Arriola	97433	June 8, 2015	
TYPE OF LEAVE REQUESTED:			
	TERNITY EDUCATIO	NAL MILITARY	JURY OTHER
PAY STATUS:	HOURS:		
W/PAY W/O PAY COME	W/PAY	32 W/OUTPAY_	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR	8)	
8:00 am May 26, 2015		י <b>י</b> י 	Charge Account NO:
	5:00 pm May 29, 2015	<u> </u>	
ADDRESS MEN E SALVEN			
ADDRESS WHILE ON LEAVE:	Philippines		
		**************************************	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10	APPLICATION FOR PREPAY	ENT OF VACATION LEAVE	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10 THE EXPIRATION OF MY PREPAID LEAVE PORTION OF THE PREPAID LEAVE	L REIMBURSE THE GOVERNMENT IN A	UNDERSTOOD THAT IF I RETURN	TO DUTY BEFORE
THE THE CLARK.			
N COMPLIANCE WITH PERSONNEL RULES AND REG	SICK LEAVE COULD SICK L	ANY CUBIOVERIO ARROWS	
	IHEE CONSECUTIVE WORKING DAVE A	<u> </u>	
THE INCAPACITY I	'RUM A MEGLII AR LICENSED DUVQICIA	N THE BEDARENS HEAR ASSESSED	
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNE UBSENCE WHICH WOULD HAVE BEEN COVERED BY S VITHOUT PAY, SICK I FAVE PORTION FOR TRIVIAL IN			
THE PROPERTY OF THE PARTY OF TH	IDISPUSITION OF FALSIFICATION OF A	AN ILLNESS REPORT SHALL BE CO	OF ABSENCE NSIDERED
THE GOV	ERNMENT SERVICE		
CERTIFY THAT THE ABOVE NAMED PERSON WAS U TELOW. FROM A MEDICAL STANDPOINT, HIS OR HEI ROM HIS OR HER TO REPORT TO WARK	NDER MY PROFESSIONAL CARE OR QU	VARANTINED DURING THE PERIOD	STATED
The state of the s		IS SUCH THAT I CONSIDERED IT IN	ADVISABLE
ROM (MONTH, DAY, YEAR): TO (MONTH	I, DAY, YEAR): HOSPITALIZ	ZED? NUMBE	R OF DAYS:
	YES	1	
		3   NO	
IAME OF PHYSICIAN (PRINT OR TYPE)	İs	IGNATURE OF PHYSICIAN	
EMARKS:			
		^	$\wedge$
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUI	E AND CORRECT (S	IGNATURE OF EMPLOYEE)	<b>!</b>
•		177~	$\mathcal{U}$ /
PPROVED		V 10	
LZ]YES LINO	lies.	CNATIOS OF OURSE, vene.	<i>X</i> 1
	(8)	GNATURE OF SUPERVISOR)	/ \
PPROVED (S	GNATURE OF APPOINTING AUTHO	ORITY OR AUTHODIZED DOLLER	
YES NO		DELEG	<i>γ</i> =')
		7	
		-	



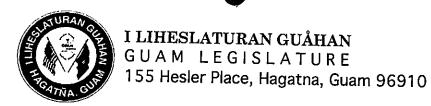
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:					
Vincent P. Arriola	97433						
TYPE OF LEAVE REQUESTED:	37700	September 4, 2015					
SICK X ANNUAL MA	TERNITY EDUCATION	DNAL MILITARY	JURY OTHER				
	INATION W/PAY	40 WOUT PAY	:15				
8:00 am September 8, 2015	TO (HOUR, MONTH, DAY, YEA 5:00 pm September 14, 2015	R):	Charge Account NO:				
ADDRESS WHILE ON LEAVE: Manila							
	ADDI ICATION FOR PRESA						
PORTION OF THE PREPAID LEAVE.	MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) CONSECUTIVE WORKING DAYS. IT IS UNDERSTOOD THAT IF I RETURN TO DUTY BEFORE THE EXPIRATION OF MY PREPAID VACATION, I SHALL REIMBURSE THE GOVERNMENT (I.M. AND UT AND AND AND AND AND AND AND AND AND AND						
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THA HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO E FURNISH A CERTIFICATION AS TO THE INCAPACITY FOR CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES ABSENCE WHICH WOULD HAVE BEEN COVERED BY SWITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL IN SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE CERTIFY THAT THE ABOVE NAMED PERSON WAS UITBELOW. FROM A MEDICAL STANDPOINT, HIS OR HEFTOM HIS OR HER TO REPORT TO WORK.	THE GOVERNMENT OF THE GOVERNMENT OF THE GOVERNMENT OF THE GOVERNMENT OF THE GOVERNMENT OF THE GOVERNMENT OF THE GOVERNMENT OF THE GOVERNMENT SERVICE.  THE THE GOVERNMENT OF THE GOVERNMENT SERVICE.  THE THE GOVERNMENT OF THE GOVERNMENT SERVICE.	RIMENT EMPLOYEE SHALL BE REQUI AN: THE DEPARTMENT HEAD MAY RE RTIFICATION REQUIRED IS NOT FURN CATED ON THE PAYROLL AS LEAVE O FAN ILLNESS REPORT SHALL BE CON	RED TO QUIRE IISHED, ALL F ABSENCE SIDERED				
FROM (MONTH, DAY, YEAR): TO (MONTH	, DAY, YEAR): HOSPITAL		OF DAYS:				
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN					
REMARKS:			1 A A				
SERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)							
PPROVED YES NO	]	SIGNATURE OF SUPERVISOR)	200				
YES NO	GNATURE OF APPOINTING AUTH	ORITY OR AUTHORIZED DELEGA	TE)				



# GUAM LEGISLATURE PEXTERNA POPULATION

JUL 232015

NAME (F	IDOT MIDDLE				. –			
NAME (F	IRST, MIDDLE, LAST):		PAYROLL NO.:		DATE REQUESTE	D:		
1	SEPH MARTINEZ E	BORJA			July 22	2, 2015		•
TYPE OF	LEAVE REQUESTED:			<u></u>	<u> </u>			
sı	CK XX ANNUAL	MAT	TERNITY	EDUCATIO	NAL N	MILITARY	JURY	OTHER
PAY STAT	US:		THO	JRS:				
X W/P	PAY WO PAY	СОМВІ	NATION	W/PAY	_8 14° w	7 23 15" //OUT PAY		
FROM (HC	DUR, MONTH, DAY, YEA	AR):	TO (HOUR, MON	ITH, DAY, YEAR):	<del></del>			
	8:00AM 7/22/15		J	·			Charge Account NO	D: 530
			5:00PM	7/22/15			<del> </del>	
ADDRESS	160 91 5 0 1 1 2 1					<del>-</del>	<u> </u>	
WDDKE22	WHILE ON LEAVE:	HAGATN	A, GUAM		<del></del>		<u> </u>	
					<u> </u>			
AINIMI IM DEC	OUR PRESENT IS NOT LIBER TO		APPLIC	ATION FOR PREPA	YENT OF VACATION	LEAVE		
THE EXPIRAT	QUIREMENT IS NOT LESS TH ION OF MY PREPAID VACATI THE PREPAID LEAVE.	IAN TEN (10) COI ON, I SHALL REII	NSECUTIVE WORKIN	G DAYS. IT IS UNDER	STOOD THAT IF I RETUR	RN TO DUTY BEFOR	E	
ORTION OF	THE PREPAID LEAVE	,		ZIAMEIAT IN AN AMOL	NT EQUIVALENT TO THE	UNEXPIRED		
	<u>. 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 </u>	<u>:::::::::::::::::::::::::::::::::::::</u>						
N COMPLIAN	CE WITH PERSONNEL RITLE	S AND DECLILAT	IONO COLUMNIA		TITLE TO A ITOM			<u></u>
LLNESS, INJU LHOUDAY 188	JRY, OR QUARANTINE IN EXC EEKEND, DAY OFF, OR VACA	CESS OF THREE	CONSECUTIVE WOR	KING DAYS, OR FOR	THE DAY IMMEDIATELY:	CAUSE OF REFORE OR A EYED	<del></del>	
URNISH A CE	EEKEND, DAY OFF, OR VACA ERTIFICATION AS TO THE INC	TION, TO BE GR,	ANTED SICK LEAVE 1	THE GOVERNMENT E	MPLOYEE SHALL BE REC	QUIRED TO		
ERTIFICATIO	N FOR SUCH OTHER PERIO	D OF ILLNESS U	COCCUCAR LICENSI	ED PHYSICIAN, THE	EPARTMENT HEAD MAY	'REQUIRE		
BSENCE WHI	ICH WOULD HAVE BEEN COV. SICK LEAVE PORTION FOR	VERED BY SUCH	CERTIFICATION SHA	ALL BE INDICATED OF	ION REQUIRED IS NOT F	URNISHED, ALL		
UFFICIENT C	SICK LEAVE PORTION FOR AUSE FOR <b>DISMISSAL</b> FROM	TRIVIAL INDISP	OSITION, OR FALSIFI	CATION OF AN ILLNE	SS REPORT SHALL BE C	ONSIDERED		
CERTIFY THA	T THE ABOVE NAMED PERS	OM WAS LINDED	MAN SECTION.				<del></del> .	
ELOW. FROM	HA MEDICAL STANDPOINT, I HER TO REPORT TO WORK.	HIS OR HER CON	DITION DURING THE	S PERIOD WAS SUCI	TINED DURING THE PERI	IOD STATED		
ROM (MON			DAY, YEAR):			INADAISABLE		
•	1 10	TO (INCIATE)	DAT, YEAR):	HOSPITALIZ	ED?	NUMBER O	F DAYS:	<del></del>
				YE	S NO			
AME OF PI	HYSICIAN (PRINT OR T	YPE)		<del></del>	GIGNATURE OF PHY	SICIAN	<del></del>	
MARKS:		<u> </u>				OIOIAII		
			· <del></del>	<u></u>	· · · · · · · · · · · · · · · · · · ·			<del></del>
		·	<u> </u>			<del></del>		<del></del>
ERTIFY ALL S	STATEMENTS MADE HEREIN	ARE TRUE AND	CORRECT	l <sub>(S</sub>	IGNATURE OF EMPLOYE	An in	_	
PROVED		<u></u>			Kongel	Ca prom	x7	
FROVED	YES/ N	0	<u></u>		<del>7 \ U -</del>	<del></del>	<del></del>	
				](s	INATURE OF SUPERVIS	SOR)	)	
PROVED		/61/	CNATURE OF ASS					
	YES NO	, (S)	GNATURE OF APP	OINTING AUTHOR	TY OR AUTHORIZED	DELEGATE)		
					-		)	
					-7	)		
					<del></del>	/		



NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:
Joseph M. Borja		November 12, 2015
TYPE OF LEAVE REQUESTED:	<u> </u>	
SICK X ANNUAL MAT	ERNITY EDUCATION	IAL MILITARY JURY OTHER
PAY STATUS:	HOURS: 0.400	
X W/PAY W/O PAY COMBI	/ Chirch	WOUT PAY
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR):	
8am November 3, 2015	5pm November 4, 2015	16 hours w/pay
1pm November 9, 2015	5pm November 9, 2015	4 hours w/pay
1pm November 10, 2015	5pm November 10, 2015	<del></del>
ADDRESS WHILE ON LEAVE:		4 hours w/pay
Home in E		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) COL	SECUTIVE MODERNIC DAVE IT IS THE	THEN OF VACATION LEAVE
THE EXPIRATION OF MY PREPAID VACATION, I SHALL REIF PORTION OF THE PREPAID LEAVE.	MBURSE THE GOVERNMENT IN AN AMOU	NT EQUIVALENT TO THE UNEXPIRED
		EDTIEICATION
N COMPLIANCE WITH REPSONNEL BUILTS AND DEGLES	SICK LEAVE O	ERTIFICATION
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATI LLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GR.	CONSECUTIVE WORKING DAVE OF FOR	
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HI	A REGULAR LICENSED PHYSICIAN, THE DEEMS ADVISABLE LIE THE CERTIFICATION	DEPARTMENT HEAD MAY REQUIRE
VITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPI SUFFICIENT CAUSE FOR <b>DISMISSAL</b> FROM THE GOVERNM		SS REPORT SHALL BE CONSIDERED
CERTIFY THAT THE ABOVE NAMED PERSON WAS LINDER	MY PROFESSIONAL CARE OF CHARACE	TINED DIRING THE REPION STATES
ROM HIS OR HER TO REPORT TO WORK.	IDITION DURING THIS PERIOD WAS SUCH	THAT I CONSIDERED IT INADVISABLE
ROM (MONTH, DAY, YEAR): TO (MONTH,	DAY, YEAR): HOSPITALIZ	ZED? NUMBER OF DAYS:
	YE	
IAME OF PHYSICIAN (PRINT OR TYPE)		
TIME OF FITTGICIAN (FRINT OR TYPE)		SIGNATURE OF PHYSICIAN
EMARKS:		
PPROVED	CORRECT	SIGNATURE OF EMPLOYEE) Jours Clu, Boxis
YES NO	1	SIGNATURE OF SUPERVISOR)
YES NO	GNATURE OF APPOINTING AUTHOR	ITY OR AUTHORIZED DELEGATE)
		20 C. Q0



# I LIHESLATURAN GUÅHAN GUAM LEGISLATURE 155 Hesler Place, Hagatna, Guam 96910

PUTALCIBIL MADE

JUN 26 2015 200 juli

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:	
	_	1 .	
DANIEL CABrera TYPE OF LEAVE REQUESTED:	97764	June	22, 2015
SICK ANNUAL MATE	ERNITY EDUCATION	AL MILITA	RY URY OTHER
PAY STATUS:	HOURS:	110	15 15 15
W/PAY W/O PAY COMBIN	IATION W/PAY	2hrs) Wout	GATIS ANTON
FROM (HOUR, MONTH, DAY, YEAR):	I TO (HOUR, MONTH, DAY, YEAR)	· I	2624 MAS GOO
8 am 6 23 15	6 26 15	CHARGE AC	CCOUNT NO.: 21 5TD
	,		
ADDRESS WHILE ON LEAVE: 127 B AB W	on Part St.	Smala	10
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) THE EXPIRATION OF MY PREPAID VACATION I SHALL	APPLICATION FOR PREPAY CONSECUTIVE WORKING DAYS, IT IS U		<del></del>
THE EXPIRATION OF MY PREPAID VACATION, I SHALL PORTION OF THE PREPAID LEAVE.	REIMBURSE THE GOVERNMENT IN AN	AMOUNT EQUIVALENT TO T	HE UNEXPIRED
IN COMPLIANCE WITH PERSONNEL RULES AND REGUI	ATIONS, GOVERNMENT OF GUAM HE A		
FURNISH A CERTIFICATION AS TO THE INCAPACITY FR	OM A REGIT AR LICENSED RIPEGOVERNA	MENT EMPLOYEE SHALL BE R	EQUIRED TO
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL IN	DISPOSITION OF THE SECRETION OF A		
CERTIFY THAT THE ABOVE NAMED PERSON WAS U BELOW. FROM A MEDICAL STANDPOINT, HIS OR HE ROM HIS OR HER TO REPORT TO WORK	R CONDITION DURING THIS PERIOD	QUARANTINED DURING THE WAS SUCH THAT I CONSIDE	PERIOD STATED
ROM (MONTH, DAY, YEAR): TO (MONTH,			
10 (MOIVIA,			JMBER OF DAYS:
	YES	, NO	
AME OF PHYSICIAN (PRINT OR TYPE)		IGNATURE OF PHYSICIA	N
EMARKS:			
LIVIANS.			
	<del></del>		
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRU	E AND CORRECT	ONATURE OF EMPLOYED	1.1
PPROVED	/		-same
LYES NO	(21	GNATURE OF SUPERVISOR)	Morning
PPROVED YES NO (SIG	NATURE OF APPOINTING AUTHOR	ITY OR AUTHORIZED DELI	EGATE)
	n 4.1		<i>'</i>
	Ummag		
	//		



# I LIHESLATURAN GUÅHAN GUAM LEGISLATURE 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE PERSONNEI (PAYROLI MEFICE

**LEAVE FORM** 

JUL 0 9 2015

NAME (TROP)				(IMC:_	100 Jan; Larm
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	D	ATE REQUESTED	RECEIV	ED BY:OCV
TYPE OF LEAVE REQUESTED:	9 994	64	7-8-1	5	
	TERNITY E	DUCATIONAL	MIL	ITARY JURY	OTHER
PAY STATUS:  W/O PAY COME	HOURS:	N/PAY	7-9-15	8 annua UTPAY <u>8 Si</u> ck	af .
FROM (HOUR, MONTH, DAY, YEAR):  5 HM  5 HL 6, +5	TO (HOUR, MONTH, DA 5 M 5 M	AY, YEAR):	CHARG	E ACCOUNT NO.:	
	, ,	<i></i>			
ADDRESS WHILE ON LEAVE:	<u> </u>	<del></del>	<del></del>		
127B AB WON PAI	ST. SINAS	ANA C	- when		
		•		<u> </u>	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (1)			NT OF VACATION L		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (IC THE EXPIRATION OF MY PREPAID VACATION, I SHAI PORTION OF THE PREPAID LEAVE.	L REIMBURSE THE GOVERN	MENT IN AN AM	ERSTOOD THAT IF I RI IOUNT EQUIVALENT 1	ETURN TO DUTY BEFORE O THE UNEXPIRED	
	SICK	LEAVE CERT	FIFICATION		
IN COMPLIANCE WITH PERSONNEL RULES AND REGI ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TH A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO FURNISH A CERTIFICATION AS TO THE INCAPACITY I CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES ABSENCE WHICH WOULD HAVE BEEN COVERED BY S WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE	BE GRANTED SICK LEAVE TH ROM A REGULAR LICENSED S HE DEEMS ADVISABLE, IF: SUCH CERTIFICATION SHALL UNDISPOSITION, OR FALSIFIC	G DAYS, OR FOR HE GOVERNMEN PHYSICIAN. TH THE CERTIFICAT BE INDICATED ATION OF AN IL	R THE DAY IMMEDIAT IT EMPLOYEE SHALL: E DEPARTMENT HEAL ITON REQUIRED IS NO ON THE PAYROLL AS LNESS REPORT SHALL	ELY BEFORE OR AFTER BE REQUIRED TO MAY REQUIRE I FURNISHED, ALL LEAVE OF ABSENCE - BE CONSIDERED	
CERTIFY THAT THE ABOVE NAMED PERSON WAS	LINDED MY DROPERSTON	L CARE OR QUA	RANTINED DURING	THE PERIOD STATED	<del></del>
ROM HIS OR HER TO REPORT TO WORK.	ER CONDITION DURING TH	HS PERIOD WA	S SUCH THAT I CONS	IDERED IT INADVISABLE	
ROM (MONTH, DAY, YEAR): TO (MONTH	, DAY, YEAR):	OSPITALIZED	?	NUMBER OF DAYS:	
		YES	NO NO	NOMBER OF DATS:	
IAME OF PHYSICIAN (PRINT OR TYPE)		ISIGN	NATURE OF PHYSI	CIAN	
			······································	JIAN	
EMARKS:					<del></del>
				_	
CERTIFY ALL STATEMENTS MADE HEREIN ARE TR	EUE AND CORRECT	(SIGN)	ATURE OF EMPLOYEE		
PPROVED	<del></del>		out!	Calle	
PPROVED S		J	ATURE OF SUPERVISO	more	
YES NO (S.	IGNATURE OF APPOINTING	G AUTHORITY	OR AUTHORIZED D	ELEGATE)	<del></del>
	Thoms	X.	rynog		
<del></del>		_(_/			



# I LIHESLATURAN GUÅHAN GUAM LEGISLATURE 155 Hessler Place, Hagatna, Guam 96910

# GUAM LEGISLATURE FEDSONIAS PROTECTION OFFICE

MAY 25 2015

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	Jn.	ATE REQUESTED:	•	<u> </u>
	ATROCE NO.		WIE VERACESIED:		
Natasha T. Cepeda			М	1AY 18, 20 K	
TYPE OF LEAVE REQUESTED:	<u> </u>	<del></del>		<u>,</u>	
SICK ANNUAL MAT	ERNITY E	DUCATIONAL	MILITAI	RY JURY	OTHER
PAY STATUS:	HOURS:		a /10 W/1	2015 401	sonia Q
W/PAY W/O PAY COMB	NOITANI	W/PAY 4	49 WOUT	PAYOCIL 24	annual sick
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH,	DAY, YEAR):	CHARGE A	CCOUNT NO.:	
MAY 18, 2015	MAY 26	17015			
ADDRESS WHILE ON LEAVE:	۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰				
	COL. GODTE P			on 19160, Gu	24/210
<u>一点,不是不是一点,不是一种人们的</u>	APPLICATION				444
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (			NT OF VACATION LEADINGERSTOOD THAT IF I		
THE EXPIRATION OF MY PREPAID VACATION, I SHAPORTION OF THE PREPAID LEAVE.	ALL REIMBURSE THE GOVE	ERNMENT IN AN	AMOUNT EQUIVALENT	TO THE UNEXPIRED	
			<del></del>	Carlot Control of the	
IN COMPLIANCE WITH PERSONNEL RULES AND RI		CK LEAVE CER NT OF GUAM, IF .		ENT BECAUSE OF	
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF	·	•			
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, T					
FURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL					•
ABSENCE WHICH WOULD HAVE BEEN COVERED					
WITHOUT PAY, SICK LEAVE PORTION FOR TRIVIA	·	SIFICATION OF A	N ILLNESS REPORT SHA	LL BE CONSIDERED	
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GI I CERTIFY THAT THE ABOVE NAMED PERSON WA		IAL CAPE OF OL	IAPANTINED DUDING TO	SE PERION STATED	
BELOW. FROM A MEDICAL STANDPOINT, HIS OR					
FROM HIS OR HER TO REPORT TO WORK.		1			
FROM (MONTH, DAY, YEAR): TO (MON	TH, DAY, YEAR):	HOSPITALIZ	ED?	NUMBER OF DAYS:	
		YES	S NO		
NAME OF PHYSICIAN (PRINT OR TYPE)	<u> </u>	<u> </u>	IGNATURE OF PHY	SICIAN	
		٦	IONATORE OF FITT	Ololait	
REMARKS:			····		
		-		NL	
I CERTIFY ALL STATEMENTS MADE HEREIN ARE	TRUE AND CORRECT	(5	SIGNATURE OF EMPLOY	EE) MAL	
APPROVED YES NO		,,	SIGNATURE OF SUPERV	USUBA 4	
		les les	SIGNATURE OF SUFERV	"On/	
APPROVED	(SIGNATURE OF APPO	OHTING AUTHIC	ORITY OR AUTHORIZE	D DELEGATE)	
YES NO					
			•		
	·				<del></del>



JUL 09 2015

IAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:				
Chauncey L.M. Colbert	97551	6/25-26/2015	5			
YPE OF LEAVE REQUESTED:			_	.		
X SICK X ANNUAL MATER	RNITY EDUCATION	NA MILITAR	y JURY	OTHER		
PAY STATUS:  X W/PAY W/O PAY COMBIN.		(16 ) W/OUT P		11hrs - Sick, 5hrs - Angual		
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR		CCOUNT NO.:			
8:00am, 6/25/15	5:00pm, 6/25/1	15		,		
8:00am, 6/26/15	5:00pm, 6/26/1	15				
ADDRESS WHILE ON LEAVE:	195 Franquez St. Maite, Gu	ıam				
	ADDLICATION FOR DE	REPAYENT OF VACATION L	EAVE			
	APPLICATION FOR FR	SUNDERSTOOD THAT IF I RET	URN TO DUTY BEFORE			
THE EXPIRATION OF MY PREPAID VACATION, I SHALL	T BEIMBORSE THE GOAEUMERS IN S	A VINCOLL FROM				
PORTION OF THE PREPAID LEAVE.						
IN COMPLIANCE WITH PERSONNEL RULES AND REG ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF T						
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO FURNISH A CERTIFICATION AS TO THE INCAPACITY CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNI						
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNI ABSENCE WHICH WOULD HAVE BEEN COVERED BY WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL						
SUFFICIENT CAUSE FOR DISMISSAL FHOM THE GO I CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR H	THIS PROPERTY OF THE PROPERTY	QUARANTINED DURING THE WAS SUCH THAT I CONSIDER	ED IT INADVISABLE			
LEDAN HIS OR HER TO REPORT TO WORK.			NUMBER OF DAYS:			
FROM (MONTH, DAY, YEAR): TO (MONTH	"		MOIMPER OF BATTO			
_		YES NO	UOLANI			
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYS	NICIAN			
REMARKS:	-					
		(SIGNATURE OF EMPLOYE	T) /	100		
I CERTIFY ALL STATEMENTS MADE HEREIN ARE T	RUE AND CORRECT	(SIGNOVICE CO. SINCE		alak.		
APPROVED YES NO (SIGNATURE OF SUPERVISOR)						
APPROVED YES NO	(SIGNATURE OF APPOINTING A	UTHORITY OR AUTHORIZE	D DELEGATE)			
			( -/			



# GUAM LEGISLATURE PERSSAMM IP ASSIGN OFFICE

JUL 23 2015

MANUEL (ELDOTE MADEL EL LACE)	Isavesi i ve				
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DA	TE REQUESTED:		
Chauncey L.M. Colbert	97551		July 13, 20	15	
TYPE OF LEAVE REQUESTED:					
SICK ANNUAL OF MATE	ERNITY EDUC	CATIONA	MILITA	RY JURY	OTHER
PAY STATUS:	HOURS:		25	10 1 1 .	T - A
X W/PAY W/O PAY COMBI	JATION W/P	YAY _Z	Webut	18 7/03/15 PAY	8-5
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY	Y, YEAR):	CHARGE A	ACCOUNT NO.:	
9:00am, 7/23/15	5:00pm, 7	1/2/15	7/		
3.00am, 1023/13 7	3.00pm, 7	VI.J. 1.J			
				·	
ADDRESS WHILE ON LEAVE:	195 Franquez St. Mait	te, Guam	<u> </u>		
HINDS IN DECLINE VALUE OF THE TEN AS			YENT OF VACATION I		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10 THE EXPIRATION OF MY PREPAID VACATION, I SHAL PORTION OF THE PREPAID LEAVE.	L REIMBURSE THE GOVERNME	ENT IN AN AM	OUNT EQUIVALENT TO	THE UNEXPIRED	
			ERTIFICATION		
IN COMPLIANCE WITH PERSONNEL RULES AND REG				T BECAUSE OF	
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TH	HREE CONSECUTIVE WORKING	DAYS, OR F	OR THE DAY IMMEDIAT	ELY BEFORE OR AFTER	
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO					
FURNISH A CERTIFICATION AS TO THE INCAPACITY I CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNE					
ABSENCE WHICH WOULD HAVE BEEN COVERED BY					
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL II		TON OF AN IL	LNESS REPORT SHALL	BE CONSIDERED	
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOV I CERTIFY THAT THE ABOVE NAMED PERSON WAS U		DE OD OHAD	ANTINED DUDING THE	DEDIOD CTATED	
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HE FROM HIS OR HER TO REPORT TO WORK.					
FROM (MONTH, DAY, YEAR): TO (MONTH,	DAY, YEAR): HO	SPITALIZE	D?	NUMBER OF DAYS:	
·		YES	□NO		
NAME OF PHYSICIAN (PRINT OR TYPE)	<u> </u>	Sig	NATURE OF PHYS	ICIAN	
DELLA DIZO		<u> </u>			
REMARKS:					
				$\sim$	
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRU	JE AND CORRECT	(SIG	NATURE OF EMPLOYER	Chal	Col
APPROVED YES NO					1
YES NO		(SIG	NATURE OF SUPERVIS	OR)	<b>&gt;</b> / .
APPROVED YES NO	(SIGNATURE OF APPOINT)	NG AUTHOF	RITY OR AUTHORIZED	DELEGATE)	
				/	

Franc Ion.
7/16 4 7/17/15



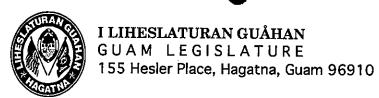
GUAM LEGISLATURE
PERSONNEN PERSONNEN PREFIEF

JUL 23 2015

	LEAV	E FORM	THE 1:45 LANGE FOR
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:	SEEWAY. V.
Chauncey L.M. Colbert	97551	July 23, 2015	activa si: XX
TYPE OF LEAVE REQUESTED:			
	ERNITY EDUCATION	NA MILITARY	JURY OTHER
PAY STATUS:	HOURS:	16,8	a st a /
X W/PAY W/O PAY COMBIN	NATION W/PAY	W/OUT PAY_	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR	R): CHARGE ACCOU	JNT NO.:
3.00pm, 7/23/15	5:00pm, 7/23/1	5	
, <u> </u>			
ADDRESS WHILE ON LEAVE: FHP Main	Clinic		
	<u> </u>		
	APPLICATION FOR PRE	EPAYENT OF VACATION LEAVE	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) THE EXPIRATION OF MY PREPAID VACATION, I SHALL PORTION OF THE PREPAID LEAVE.	L REIMBURSE THE GOVERNMENT IN AN	N AMOUNT EQUIVALENT TO THE UN	IEXPIRED
IN COMPLIANCE WITH PERSONNEL RULES AND REGI	SICK LEAV ULATIONS, GOVERNMENT OF GUAM, IF	VE CERTIFICATION  F ANY EMPLOYEE IS ABSENT RECALL	ISE OF
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TH	IREE CONSECUTIVE WORKING DAYS, O	OR FOR THE DAY IMMEDIATELY BEF	FORE OR AFTER
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO E FURNISH A CERTIFICATION AS TO THE INCAPACITY F	ROM A REGULAR LICENSED PHYSICIAL	N. THE DEPARTMENT HEAD MAY RE	EQUIRE
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES	SS HE DEEMS ADVISABLE. IF THE CERT	TIFICATION REQUIRED IS NOT FURN	NISHED, ALL
ABSENCE WHICH WOULD HAVE BEEN COVERED BY S WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL IN	BUCH CERTIFICATION SHALL BE INDICATION OF A	ATED ON THE PAYROLL AS LEAVE O	OF ABSENCE
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE	ERNMENT SERVICE.		
I CERTIFY THAT THE ABOVE NAMED PERSON WAS UIT	NDER MY PROFESSIONAL CARE OR OF	UARANTINED DURING THE PERIOD	STATED
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HEF FROM HIS OR HER TO REPORT TO WORK.		AS SUCH THAT I CONSIDERED IT INA	ADVISABLE
FROM (MONTH, DAY, YEAR): TO (MONTH,	DAY, YEAR): HOSPITAL	IZED? NUMBE	ER OF DAYS:
	_	ES NO	
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUI	E AND CORRECT	(SIGNATURE OF EMPLOYEE)	1/2/20
APPROVED			Conery
YES NO	l s	(SIGNATURE OF SUPERVISOR)	<del>/</del> /
APPROVED YES NO	(SIGNATURE OF APPOINTING AUTH	HORITY OR AUTHORIZED DE LEG	atox.
		_	$\mathcal{U}$



NAME (FIRST, MIDDLE, LAST):	IPAYROLL NO.:	DATE REQUESTED:				
Chauncey L.M. Colbert	97551					
TYPE OF LEAVE REQUESTED:	9/331	7/29-8/3/2015				
	RNITY EDUCATION	IAL MILITARY JURY OTHER				
PAY STATUS:	HOURS:					
X W/PAY W/O PAY COMBIN	IATION W/PAY	WOUT PAY				
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR	CHARGE ACCOUNT NO.:				
8:00am, 7/29/15	5:00pm, 7/29/1	5				
8:00am, 8/3/ <u>1</u> 5	5:00pm, 8/3/15					
3am 8/11/15	5pm 87	15				
ADDRESS WHILE ON LEAVE:	195 Franquez St. Maite, Gue	ım				
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10)	APPLICATION FOR PRE	PAYENT OF VACATION I FAVE				
THE EXPIRATION OF MY PREPAID VACATION, I SHALL PORTION OF THE PREPAID LEAVE.	REIMBURSE THE GOVERNMENT IN AN	AMOUNT EQUIVALENT TO THE UNEXPIRED				
IN COMPLIANCE WITH PERSONNEL RULES AND REGU	SIGRLEAV	E CERTIFICATION				
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TH	REE CONSECUTIVE WORKING DAYS, O	R FOR THE DAY IMMEDIATELY REFORE OR ASTER				
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO B FURNISH A CERTIFICATION AS TO THE INCAPACITY F	E GRANTED SICK LEAVE THE GOVERN	MENT EMPLOYEE SHALL BE DECLIDED TO				
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES	SS HE DEEMS ADVISABLE, IF THE CERT	IFICATION REQUIRED IS NOT ELIBNISHED, ALL				
VESSURE MHICH MOOFD HAVE BEEN COVERED BAS	BUCH CERTIFICATION SHALL BE INDICA	TED ON THE PAYROLL AS LEAVE OF ARCENICS				
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INI SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE	DISPOSITION, OR FALSIFICATION OF AI FRAMENT SERVICE.	NILLNESS REPORT SHALL BE CONSIDERED				
I CERTIFY THAT THE ABOVE NAMED PERSON WAS UN	DER MY PROFESSIONAL CARE OR OL	ARANTINED DURING THE PERIOD STATED				
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER FROM HIS OR HER TO REPORT TO WORK.	CONDITION DURING THIS PERIOD WA	S SUCH THAT I CONSIDERED IT INADVISABLE				
FROM (MONTH, DAY, YEAR): TO (MONTH, I	DAY, YEAR): HOSPITALI	ZED? NUMBER OF DAYS:				
	YE	s No				
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN				
REMARKS:						
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)						
		Calal				
APPROVED YES NO		0 /				
(SIGNATURE OF SUPERVISOR)						
APPROVED YES NO	SIGNATURE OF APPOINTING AUTH	ORITY OR AUTHORIZED DELEGATE)				
		·				



NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	IDATE DECLEDED	
To and ( mor, model, 1201).	FAIROLL NO.,	DATE REQUESTED:	
Eliza G. Dames		July 31, 20	15
TYPE OF LEAVE REQUESTED:			
SICK X ANNUAL MAT	FERNITY EDUCATION	NAL MILIT	ARY JURY OTHER
PAY STATUS:	HOURS:	C) 4/0m	08-06-15
X W/PAY W/O PAY COMBI	INATION W/PAY	32 hours Wour	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR):		Charge Account NO:
Friday, July 31, 2015	Wednesday, August 5, 2015	sl .	Onaige Account NO.
	, , , , , , , , , , , , , , , , , , ,	<del></del>	
		<del>                                     </del>	
ADDRESS WHILE ON LEAVE: Vacation	-		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) CO	APPLICATION FOR PREP	AYENT OF VACATION LFA	VE .
THE EXPIRATION OF MY PREPAID VACATION, I SHALL RE	IMBURSE THE GOVERNMENT IN AN AMOR	KSTOOD TRAITET RETURN TO UNT EQUIVALENT TO THE UNE	DUTY BEFORE EXPIRED
PORTION OF THE PREPAID LEAVE.			
		CERTIFICATION	
IN COMPLIANCE WITH PERSONNEL RULES AND REGULA	ITIONS, GOVERNMENT OF GUAM, IF ANY	EMPLOYEE IS ASSENT RECALL	SE OF
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THRE	E CONSECUTIVE WORKING DAYS, OR FOR	R THE DAY IMMEDIATELY BEFO	ORE OR AFTER
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GI FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM	RANTED SICK LEAVE THE GOVERNMENT I	EMPLOYEE SHALL BE REQUIR	ED TO
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS	HE DEEMS ADVISABLE. IF THE CERTIFICA	ITION REQUIRED IS NOT FURN	IISHED, ALL
ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUC	CH CERTIFICATION SHALL BE INDICATED O	ON THE PAYROLL AS LEAVE OF	ARSENCE
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDIS SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVERN	POSITION, OR FALSIFICATION OF AN ILLN NMENT SERVICE.	IESS REPORT SHALL BE CONS	IDERED
I CERTIFY THAT THE ABOVE NAMED PERSON WAS UND	ER MY PROFESSIONAL CARE OR QUARA	NTINED DURING THE PERIOD	STATED
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CO FROM HIS OR HER TO REPORT TO WORK.	ONDITION DURING THIS PERIOD WAS SUC	CH THAT I CONSIDERED IT INA	DVI\$ABLE
	H, DAY, YEAR): HOSPITAL	IZED2	NUMBER OF DAYS:
	<del>                                 </del>		HOMBER OF DATA.
	L  <sup>*</sup>	ES NO	
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSIC	CIAN
,		0.	50° U 3
REMARKS:		<u> </u>	
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE A	ND COURSE		44 0 0
OERTIFF ALLSTATEMENTS MADE HEREIN ARE TRUE AL	ND CORRECT	(SIGNATURE OF EMPLOYEE)	6 Ossa de Dans
			Elsza G. Dame
APPROVED YES NO			1 0 0
<b>₩</b> 123	1	(SIGNATURE OF SUPERVISOR	» / <del>-</del>
		<u></u>	
APPROVED YES NO	SIGNATURE OF APPOINTING AUTHO	ORITY OR AUTHORIZED DE	LEGATE)
			ť
	<del></del> -	. <u> </u>	



### GUAN LEGISLATURE ERSCHWELLPAYROLL OFFICE

DEC 2 3 2015

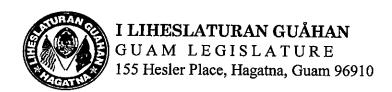
			ing D -	DIE	~ 1 6 X	I TORE
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:		IVEC BY	- A C ()	<del></del> ^
Blaine A. Dydasco		December 21	, 2015	IVEC BY	· Vyai	1
TYPE OF LEAVE REQUESTED:				· · · · · ·		
SICK ANNUAL MA	TERNITY EDUC	CATIONAL MILIT	ARY	JURY		OTHER
PAY STATUS:	HOURS	( a) >				
W/PAY W/O PAY COME	BINATION W/P.	AK 32 hars 8.0. WOU	T PAY	_		
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY,	YEAR):	Charge	e Account NO	· 530	<del></del>
8am December 21, 2015	5pm December 24, 2	2015	- January.		. 550	<del></del>
ADDRESS WHILE ON LEAVE:						<del>.</del>
Santa R	ita, Guam 96915					
						1000000
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) (	CONSECUTIVE WORKING DAYS. IT		O DUTY BEFORE			
THE EXPIRATION OF MY PREPAID VACATION, I SHALL F PORTION OF THE PREPAID LEAVE.	EIMBURSE THE GOVERNMENT IN	AN AMOUNT EQUIVALENT TO THE UN	EXPIRED			
						::::::::::::::::::::::::::::::::::::::
IN COMPLIANCE WITH PERSONNEL RULES AND REGUL		LEAVE CERTIFICATION IF ANY EMPLOYEE IS ABSENT BECAU	JSE OF			
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THR A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE						
FURNISH A CERTIFICATION AS TO THE INCAPACITY FRO	DM A REGULAR LICENSED PHYSICI	IAN. THE DEPARTMENT HEAD MAY RE	QUIRE			
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES: ABSENCE WHICH WOULD HAVE BEEN COVERED BY SL				A.,		
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL IND	ISPOSITION, OR FALSIFICATION OF					
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVER I CERTIFY THAT THE ABOVE NAMED PERSON WAS UNI	DER MY PROFESSIONAL CARE OR					
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER ( FROM HIS OR HER TO REPORT TO WORK.	CONDITION DURING THIS PERIOD I	WAS SUCH THAT I CONSIDERED IT IN	ADVISABLE			
FROM (MONTH, DAY, YEAR): TO (MON	TH, DAY, YEAR): HO	SPITALIZED?	NUMBER OF DAY	S:		
	n	YES NO				
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYS	CIAN			
REMARKS:						
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE	AND CORRECT	(SIGNATURE OF EMPLOYEE	)			
APPROVED YES NO		(SIGNATURE OF SUPERVISO	R) IC (	<u> </u>	20	<del></del>
APPROVED YES NO	(SIGNATURE OF APPOINTING	AUTHÓRITY OR AUTHORÍZED D	ELEGATE)			
,	-	2-7				
					<b>→</b> `	



# GUAM LEGISLATURE PERSONNEL / PAYROLL OFFICE

DEC 2 3 2015

					門務都研	· <u>U 70</u>	TX248 [	] PM
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:		DATE REC	UESTED:	1, 5	WED BY:	ANBW	
Lourdes Pimentel Eclavea	97834		Dece	ember 14,	2015			· ·
TYPE OF LEAVE REQUESTED:	.L		1					
SICK ANNUAL MA	ATERNITY E	EDUCATIO	NAL _	MILITA	RY	JURY		OTHER
PAY STATUS:	HOURS:		^	(RM)			Othe "Bereave	
W/PAY W/O PAY COME	BINATION	W/PAY	40	YW W/OUT	PAY		(Consang	uinity)
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH,			- 102-		Charge Accoun	nt NO:	
0800, December 14, 2015	1700, December	15, 2015	hrs (A7	כעומן,				501
0800, December 16, 2015	1700, December	18, 2015	(4)hrs (A3	) amuligr	ท			501
								•
ADDRESS WHILE ON LEAVE: Agana I	łeights, Guam							
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (1	APPLICATION					MY DEEODE		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (T THE EXPIRATION OF MY PREPAID VACATION, I SHA PORTION OF THE PREPAID LEAVE.								
	e:	CK LEAVE (	EDTIEVAT	ON				
IN COMPLIANCE WITH PERSONNEL RULES AND RE					BECAUSE	OF	<u> </u>	
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF T	THREE CONSECUTIVE WOR	RKING DAYS,	OR FOR THE I	DAY IMMEDIATI	ELY BEFORI	E OR AFTER		i
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO FURNISH A CERTIFICATION AS TO THE INCAPACITY								
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLN	ESS HE DEEMS ADVISABLE	E. IF THE CER	TIFICATION F	EQUIRED IS NO	OT FURNISH	HED, ALL		
ABSENCE WHICH WOULD HAVE BEEN COVERED BY WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL								
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GO	VERNMENT SERVICE.							
I CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR H								
FROM (MONTH, DAY, YEAR): TO (MON	TH, DAY, YEAR):	HOSPITAI	JZED?		NUMBER	OF DAYS:		-
		Y	ES	NO				
NAME OF PHYSICIAN (PRINT OR TYPE)			SIGNATU	RE OF PHYS	ICIAN			-
REMARKS:			!					
			<u> </u>			$\overline{}$		
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TR	LUE AND CORRECT		(SIGNATURE	OF EMPLOYE	E)	Mall	Jan	i
APPROVED YES NO			(SIGNATURE	OF SUPERVIS	(OR)		and the second second	
APPROVED YES NO	(SIGNATURE OF APPO	INTING AUT	HORITY OR	AUTHORIZED	DELEGAT			



NOV 25 2015 AUC X

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:		IDATE DECLIERTED				
I INOT, MIDDLE, DAOT).	PATROLL NO.:		DATE REQUESTED:				
Julian, C, Janssey	<u>'</u>		11/23/2015	•			
TYPE OF LEAVE REQUESTED:			<u> </u>				
SICK ANNUAL MA	TERNITY E	DUCATIO	NAL MILIT	ARY JURY OTHER			
PAY STATUS:	HOURS:		11 MARIAN -	76			
W/PAY W/O PAY COMB	MATION	V/PAY	W/ou	T PAY			
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, D	DAY, YEAF	R):	Chara Assuration			
11:00 pm 11/2 3/2015	12- 11/23/	2015		Charge Account NO:			
		***					
ADDRESS WHILE ON LEAVE:							
Hanatra au							
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10)	CONSECUTIVE WORKING	OR PREPA DAYS, IT IS	YENT OF VACATION LEA	AVE			
THE EXPIRATION OF MY PREPAID VACATION, I SHALL PORTION OF THE PREPAID LEAVE.	REIMBURSE THE GOVERN	MENT IN A	NAMOUNT EQUIVALENT TO	THE UNEXPIRED			
	<del></del>	KIEAVEC	ERTIFICATION				
IN COMPLIANCE WITH PERSONNEL RULES AND REGU	JLATIONS, GOVERNMENT C	OF GUAM, IF	ANY EMPLOYEE IS ABSEN	T BECAUSE OF			
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TH A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO E FURNISH A CERTIFICATION AS TO THE INCAPACITY F CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES ABSENCE WHICH WOULD HAVE BEEN COVERED BY S WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL IN SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE	BE GRANTED SICK LEAVE T ROM A REGULAR LICENSE SS HE DEEMS ADVISABLE. SUCH CERTIFICATION SHAL IDISPOSITION, OR FALSIFIC ERNMENT SERVICE.	HE GOVERN D PHYSICIAI IF THE CER' LL BE INDICA CATION OF A	NMENT EMPLOYEE SHALL E N. THE DEPARTMENT HEAD TIFICATION REQUIRED IS N ATED ON THE PAYROLL AS AN ILLNESS REPORT SHALL	BE REQUIRED TO D MAY REQUIRE HOT FURNISHED, ALL LEAVE OF ABSENCE L BE CONSIDERED			
I CERTIFY THAT THE ABOVE NAMED PERSON WAS U BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER FROM HIS OR HER TO REPORT TO WORK.	NDER MY PROFESSIONAL ( R CONDITION DURING THIS	CARE OR QI PERIOD WA	UARANTINED DURING THE AS SUCH THAT I CONSIDER	PERIOD STATED ED IT INADVISABLE			
	H, DAY, YEAR):	OSPITAL	IZED?	NUMBER OF DAYS:			
		YE	ES NO	·			
NAME OF PHYSICIAN (PRINT OR TYPE)	· · · · · · · · · · · · · · · · · · ·		SIGNATURE OF PHYS	SICIAN			
REMARKS:							
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)							
APPROVED (SIGNATURE OF SUPERVISOR)							
APPROVED YES NO	SIGNATURE OF APPOIN	TING AUTH	ORITY OR AUTHORIZED	DELEGATE)			



DESCUMPLIBAZIONI GEELCE DUAM FEDIOLATICKE

SFP 17 2015

NAME (FIRST, MIDDLE, LAST):	DAVDOLL NO		CEIAED RI: TAKK	771	
h h	PAYROLL NO.:	DATE REQUESTED:			7
Joseffe Javelosa	97818	7/7/16			
TYPE OF LEAVE REQUESTED:				4=0	-
SICK ANNUAL MA	TERNITY EDUCATION	ONAL MILITARY	JURY	OTHER	
PAY STATUS:	HOURS:	OAMW	1	-	_
W/PAY W/O PAY COMB	INATION W/PAY	WOUTPAY WOUTPAY	·15	U CTO 140 Annua	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEA	IBI:	<del></del>		_
lug 31,2015	Sept 25,2015	1	Charge Account	2411	PE9:5
18:00 AM	5:00 PM		0	COUP. 6	1,10,15
			1 1	COMP Ann Dong	10 15
ADDRESS WHILE ON LEAVE:	CM.T A	rainland	11	2 Ann. ppe 9. 0 ANN. ppe 10-03	
Ŋν	1 CALL N			••	פון
	APPLICATION FOR PREPA	YENT OF VACATION LEAVE			
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10 THE EXPIRATION OF MY PREPAID VACATION, I SHAL PORTION OF THE PREPAID LEAVE	II CONSECUTIVE WADDING BAVE IF	10 LISTON CONTRACTOR OF THE CO	DUTY BEFORE	(A) Printing	
PORTION OF THE PREPAID LEAVE.		AN AMOUNT EQUIVALENT TO THE UN	EXPIRED	/ Ann HPS	
	SICK LEAVE (	ERTIFICATION		90-408/97/90/97/37 (***)50/5	
N COMPLIANCE WITH PERSONNEL RULES AND REGI LLNESS, INJURY, OR QUARANTINE IN EXCESS OF TH A HOUDAY, WEEKEND, DAY OFF, OR VACATION, TO I	ULATIONS, GOVERNMENT OF GUAM	IF ANY EMPLOYEE IS ABBENT BECAU		PERSONNEL PRINCIPLE O	4 pm .
				4 SURSCIANTA NO. 50	
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNE	SO HE DEEMS ADVISABLE OF THE OF	IAN. THE DEPARTMENT HEAD MAY RE	QUIRE	OCT 0 1	
ABSENCE WHICH WOULD HAVE BEEN COVERED BY S WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL IN SUFFICIENT CAUSE FOR DIMMERAL FROM THE COUR				11600: 1100 V	
				RECEIVED BY: WAR	\1
CERTIFY THAT THE ABOVE NAMED PERSON WAS U ELOW. PROM A MEDICAL STANDPOINT, HIS OR HEI ROM HIS OR HER TO REPORT TO WASK	NDER MY PROFESSIONAL CARE OF	QUARANTINED DURING THE PERIOD 8	TATED	The second section 1911.	*A1
The state of the s			DYISABLE		
MONTH, DAT, TEAH): 10 (MONTH	, DAY, YEAR): HOSPITAL	IZED? NUMBER	OF DAYS:		
	YE	S NO			
IAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN			
Christian Company					
EMARKS:					
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE	LAND CORRECT	······································	(a()		
A .	E AND CORRECT	SIGNATURE OF EMPLOYED	auton	<b>^</b>	
PPROVED T					
YES NO	l s	IIGNATURE OF BUT ERVISOR)			
PROVED			•	J	
PPROVED YES NO (SIG	SNATURE OF APPOINTING AUTH	ORITY OF AUTHORIZED DECEGAT	E)		
		4			
		///	/	]	
	<del></del>				

Guam Leuislatune Fersonnei ioanoga needer



#### I LIHESLATURAN GUÄHAN GUAM LEGISLATURE 155 Hessler Place, Hagatna, Guam 96910

		13127X V 1		L		
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	I	DATE REQUE	STED:	2/22/15	
Velma M. Komiyama	97426				9/23/15	
TYPE OF LEAVE REQUESTED:	_			_		
SICK ANNUAL MA		UCATION	AL	MILITA	RY JURY	OTHER
W/PAY W/O PAY COMB	HOURS:	/PAY	ITANK	) Wiour	PAY	
						. •
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, D.	1	_ 1	CHARGE	ACCOUNT NO.:	
DPM 9/30/15	5 pm	10/9	શહ			
	1	i	1			
ADDRESS WHILE ON LEAVE:	gas, NV					
	APPLICATION			ATION LEA	Vaci	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN THE EXPIRATION OF MY PREPAID VACATION, I SH PORTION OF THE PREPAID LEAVE.	(10) CONSECUTIVE WORKING	G DAYS. IT IS	UNDERSTOOD	THAT IF I RET	URN TO DUTY BEFORE	
			OF DETICATION			
IN COMPLIANCE WITH PERSONNEL RULES AND R	EGULATIONS, GOVERNMENT	OF GUAM, I		E IS ABSENT		<del>,</del>
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, 1						
FURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL						
ABSENCE WHICH WOULD HAVE BEEN COVERED IN WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA	BY SUCH CERTIFICATION SHA	ALL BE INDIC	ATED ON THE P.	AYROLL AS L	EAVE OF ABSENCE	
SUFFICIENT CAUSE FOR DISMISSAL FROM THE G	OVERNMENT SERVICE.					
I CERTIFY THAT THE ABOVE NAMED PERSON WA BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.						
FROM (MONTH, DAY, YEAR): TO (MON	TH, DAY, YEAR): H	OSPITALI	ZED?		NUMBER OF DAYS:	
		YE	S NO	)		
NAME OF PHYSICIAN (PRINT OR TYPE)	<u> </u>	8	SIGNATURE C	F PHYSICI	AN	
REMARKS:					, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				<u></u>	10	
I CERTIFY ALL STATEMENTS MADE HEREIN ARE T	TRUE AND CORRECT	¢	SIGNATURE OF E	MPLOYEE)	Uf on.	4
APPROVED YES NO		(6	SIGNATURE OF S	SUPERVISOR	Chirpme 6	. of
APPROVED YES NO	GIGNATURE OF APPOIN	TING AUTH	ORITY OR AUT	HORIZED D	ELEGATE)	
	h	lv6	人			
			10		·· / · · · · · · · · · · · · · · · · ·	
LEAVE APPLICATION FORM (rev. 08.30.03)						GENERATED BY MIS



### I LIHESLATURAN GUÄHAN GUAM LEGISLATURE 155 Hessler Place, Hagatna, Guam 96910

Guam leuislature Pregnast iotypott getter

OCT 1.5 2015

HANGE DOOR OF THE PROCESS BY: DOOR OF TH

	LL	AVEFORM	The state of the s
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:	<del></del>
Velma M. Komiyama	97426	9	23/15
TYPE OF LEAVE REQUESTED:			
Maick MANNUAL MA		ATIONAL MILITARY	JURY OTHER
W/PAY W/O PAY COMBI	HOURS: NATION W/PAY	(12) 1015/15 WOUT PA	Ann. 32 thrs  Cick 48 Hrs
11   12   13   15   15   15   15   15   15   15	TO (HOUR, MONTH, DAY,	YEAR): CHARGE ACC	OUNT NO.:
8 km 10/2/17	DOM 101	12/18	
ADDRESS WHILE ON LEAVE:			
Las Veg	•		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (1	0) CONSECUTIVE WORKING DAY	S IT IS HADEBOTOOD THAT IS I BETTER	
PORTION OF THE PREPAID LEAVE.	LL REIMBURSE THE GOVERNME	NT IN AN AMOUNT EQUIVALENT TO THE U	NEXPIRED
IN COMPLIANCE WITH PERSONNEL RULES AND REC	GULATIONS, GOVERNMENT OF C	EAVE CERTIFICATION  UAM, IF ANY EMPLOYEE IS ABSENT BECA	USE OF
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF T A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO	HREE CONSECUTIVE WORKING	DAVS OF FOR THE DAY BASEDUATE, Wind	
LOVAIGH Y CENTIFICATION AS TO THE INCAPACITA	FROM A REGULAR LICENSED DE	IVEICIAN THE DEPARTMENT HEAD	
ABSENCE WHICH WOULD HAVE BEEN COVERED BY	ESS HE DEEMS ADVISABLE.	HE CERTIFICATION REQUIRED IS NOT FUR	NISHED, ALL
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVERNMENT.	INDISPOSITION, OR FALSIFICATI	ON OF AN ILLNESS REPORT SHALL BE CO	NSIDERED
CERTIFY THAT THE ABOVE NAMED PERSON WAS	UNDER MY PROFESSIONAL CAR	E OR QUARANTINED DURING THE PERIOD	STATED
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HI FROM HIS OR HER TO REPORT TO WORK.	ER CONDITION DURING THIS PER	ROD WAS SUCH THAT I CONSIDERED IT IN	ADVISABLE
FROM (MONTH, DAY, YEAR): TO (MONTH	I, DAY, YEAR): HOSP	ITALIZED? NUM	BER OF DAYS:
		YES NO	
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
	<del></del>		
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRI	JE AND CORRECT	(SIGNATURE OF EMPLOYEE)	A . 4 -
APPROVEQ [ ]		Vi	1-121
TTIAES TINO	<b>\</b> 1	(SIGNATURE OF SUPERVISOR)	7119
PPROVED YES NO	IGNATURE OF APPOINTING	AUTHORITY OR AUTHORIZED DELEGA	TE) (   //
<u> </u>	M	lunk	
<del>/</del>	1 1 1	<del>-  </del> -	<u> </u>
	_ /	L	l .



### GUAM LEGISLATURE PERSONNER PERSONNER PREFICE

JUL 23 7015

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:									
Kennet l. W. Comboniero	97431	07/23/15									
TYPE OF LEAVE REQUESTED:	7 162 51	0729.5									
SICK ANNUAL MATERNITY EDUCATIONAL MILITARY JURY OTHER											
PAY STATUS:	HOURS:	(1) 110 2/02/1=									
	INATION W/PAY	(14) 1/2 7/23/15 W/OUT PAY									
FROM (HOUR, MONTH, DAY, YEAR): 8 iv 07/23/15	TO (HOUR, MONTH, DAY, YEA 5:00 07/23/15	R): Charge Account NO	:								
8:00 07/34/15	5:N 07/24/15										
7/23/15	5-W 7/22/15 ,										
		Chola Pugo Grum 94940	,								
		YENT OF VACATION LEAVE									
THE EXPIRATION OF MY PREPAID VACATION, I SHALL PORTION OF THE PREPAID LEAVE.	D) CONSECUTIVE WORKING DAYS. IT IL REIMBURSE THE GOVERNMENT IN	S UNDERSTOOD THAT IF I RETURN TO DUTY BEFORE AN AMOUNT EQUIVALENT TO THE UNEXPIRED									
IN COMPLIANCE WITH PERSONNEL RULES AND REC	SICK LEAVE ( SULATIONS, GOVERNMENT OF GLIAM.	CERTIFICATION  IF ANY EMPLOYEE IS ABSENT RECAUSE OF									
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF T A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO FURNISH A CERTIFICATION AS TO THE INCAPACITY CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNE ABSENCE WHICH WOULD HAVE BEEN COVERED BY WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL I SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOV I CERTIFY THAT THE ABOVE NAMED PERSON WAS I	BE GRANTED SICK LEAVE THE GOVE FROM A REGULAR LICENSED PHYSIC ESS HE DEEMS ADVISABLE. IF THE CE SUCH CERTIFICATION SHALL BE INDI NDISPOSITION, OR FALSIFICATION OF (ERNMENT SERVICE.	IAN. THE DEPARTMENT HEAD MAY REQUIRE RTIFICATION REQUIRED IS NOT FURNISHED, ALL CATED ON THE PAYROLL AS LEAVE OF ABSENCE FANILLNESS REPORT SHALL BE CONSIDERED									
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HE	R CONDITION DURING THIS PERIOD V	VAS SUCH THAT I CONSIDERED IT INADVISABLE									
FROM HIS OR HER TO REPORT TO WORK. FROM (MONTH, DAY, YEAR): TO (MONTI	H, DAY, YEAR): HOSPITAI	IZED? NUMBER OF DAYS:									
		ES NO									
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN									
REMARKS:											
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)											
APPROVED YES NO		(SIGNATURE OF SUPERVISOR)	2								
APPROVED YES NO	SIGNATURE OF APPOINTING AUT	HORITY OR AUTHORIZED DELEGATE)									



NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED	
11	ATTIOLE NO		<b>.</b>
Kenneth W. Lambruser	97431	07/26/15	
TYPE OF LEAVE REQUESTED:			Bevenuement
	TERNITY EDUCAT	·····	TARY JURY OTHER
PAY STATUS:	HOURS:	32 Jy (4	Businet King set Annual
F:00 07/27/18	W/PAY	/r- w/ol	UTPAYOMEON DO .UL.15
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YE 5:00 07/30/15	EAR):	Charge Account NO:
8:W 18/03/15	5:00 08/13/15		
fiw 18/04/15	5:10 04/14/15		
ADDRESS WHILE ON LEAVE:		100	
5 Me Mai Man Road	Chala Profo Grunn	1 310 ysing s	ing Dede to Gruam
	APPLICATION FOR PRE	4.4 3 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (1	0) CONSECUTIVE WORKING DAYS.	PAYENT OF VACATION LITTIS UNDERSTOOD THAT IF	I RETURN TO DUTY BEFORE
THE EXPIRATION OF MY PREPAID VACATION, I SHA PORTION OF THE PREPAID LEAVE.	LL REIMBURSE THE GOVERNMENT	IN AN AMOUNT EQUIVALEN	T TO THE UNEXPIRED
		E CERTIFICATION	
IN COMPLIANCE WITH PERSONNEL RULES AND REC	BULATIONS, GOVERNMENT OF GUA	M, IF ANY EMPLOYEE IS AB	SENT BECAUSE OF
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF 1 A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO	HREE CONSECUTIVE WORKING DA	YS, OR FOR THE DAY IMMEI	DIATELY BEFORE OR AFTER
FURNISH A CERTIFICATION AS TO THE INCAPACITY	FROM A REGULAR LICENSED PHYS	SICIAN, THE DEPARTMENT H	EAD MAY REQUIRE
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLN	ESS HE DEEMS ADVISABLE. IF THE	CERTIFICATION REQUIRED	IS NOT FURNISHED. ALL
ABSENCE WHICH WOULD HAVE BEEN COVERED BY WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL	SUCH CERTIFICATION SHALL BE II INDISPOSITION, OR FALSIFICATION	IDICATED ON THE PAYROLL FOR AN ILLNESS REPORT SE	AS LEAVE OF ABSENCE HALL BE CONSIDERED
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GO	VERNMENT SERVICE.		
I CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR HI	UNDER MY PROFESSIONAL CARE ( ER CONDITION DURING THIS PERIO	OR QUARANTINED DURING T D WAS SUCH THAT I CONSID	HE PERIOD STATED
FROM HIS OR HER TO REPORT TO WORK.			ZERED II IRADVISABLE
FROM (MONTH, DAY, YEAR): TO (MONT	H, DAY, YEAR): HOSPIT	ALIZED?	NUMBER OF DAYS:
		YES NO	
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHY	/SICIAN
REMARKS:	<del> </del>		
HEMANIO.			
CERTIFY ALL STATEMENTS MADE HEREIN ARE TR	UE AND CORRECT	(SIGNATURE OF EMPLOY	(FE)
		(0/4/10/10/10/10/10/10/10/10/10/10/10/10/10/	Chy
APPROVED	· · · · · · · · · · · · · · · · · · ·		
YES NO		(SIGNATURE OF SUPERV	ISO(R)
APPROVED YES NO	SIGNATURE OF APPOINTING A	UTHORITY OR AUTHORIZ	ZED DELEGATE)
Y YES NO			
			/ / )

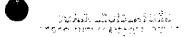


# I LIHESLATURAN GUÅHAN GUAM LEGISLATURE 155 Hessler Place, Hagatna, Guam 96910

BENERAL MANNE MENT

APR 29 2015 3:30

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	· · · · · · · · · · · · · · · · · · ·	DATE REQUE	STED:		<del></del>
	_				•	
JOHN DEPEK ANTONIO LUCES	97783		4-28-1	15 *	2 5-1-15	
TYPE OF LEAVE REQUESTED:	<u> </u>					
SICK X ANNUAL MAT	ERNITY E	DUCATION	AL	MILITAF	RY JURY	OTHER
PAY STATUS:	HOURS:			110	l.al.e	
W/PAY W/O PAY COMBI	NATION	W/PAY		W/OUT I	30 15 PAY	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH,	DAY, YEAR	: CH	IARGE A	CCOUNT NO.:	
8M-11-28-15	BPM 5-1-1	5		A OL A	0000N1 No	
ADDRESS WHILE ON LEAVE:	<u>.                                    </u>	<del></del> -				
SACRAMENTO, CALIFORNIA						
		A 18 (2) 18 (4)	(80m) (2) (	REPORT	alia (silanga daga) andaga (sila	AMARK II.
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (1	<ol><li>CONSECUTIVE WORKI</li></ol>	NG DAYS IT IS	ENT OF VACAT	TUAT IC I D	SETTION TO DUTY DEEDOE	
THE EXPIRATION OF MY PREPAID VACATION, I SHA FORTION OF THE PREPAID LEAVE.						
· 2000 产品。如此为6000分别。 * 等中的数据输出	(2000) (1000) (1000) IS	CKIEAVEC	ERTIFICATION	CACHO.	<b>東京選手を与てい会場のスプルク</b>	
IN COMPLIANCE WITH PERSONNEL RULES AND RE	GULATIONS, GOVERNME	NT OF GUAM	E ANY EMPLOYE	E IS ABSE	NT BECAUSE OF	
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO ELIDALISH A CERTIFICATION AS TO THE WORLD OF	THREE CONSECUTIVE WO	RKING DAYS	OR FOR THE DAY	VIMMEDIA	TEL VICEORE OR ARTER	
I OUMBING CONTINUATION AS TO THE INCAPACITY	FROM A REGULAR LICEN	ISED PHYSICU	IN THE DEPART	MICHT LIE	AD MAY DECLIDE	
CELLINICATION FOR SOCIA OTHER REGIOD OF ITTU	ESS HE DEEMS ADVISARI	I E IE THE CER	TIEICATION DEO	MINOED IC:	MOT GUOMICHEO ALL	•
ABSENCE WHICH WOULD HAVE BEEN COVERED BY WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL SHEELCHENT CAUSE FOR DISMISSALE FOR THE CO.	INDISPOSITION, OR FALS	HALL BE INDIC IFICATION OF	ATED ON THE PA AN ILLNESS REP	AYROLL AS ORT SHAL	S LEAVE OF ABSENCE	
SOLLIGIES CHOSE FOR DISMISSAT FROM THE GO	VERNMENT SERVICE.					
I CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR H	UNDER MY PROFESSION ER CONDITION DURING T	AL CARE OR ( THIS PERIOD W	MARANTINED DI	URING TH	E PERIOD STATED	
TROM HIS OR HER TO REPORT TO WORK.				CONSIDE	RED (I INADVISABLE	·
FROM (MONTH, DAY, YEAR): TO (MONT	H, DAY, YEAR):	HOSPITAL	ZED?	1	NUMBER OF DAYS:	
		YE	s No			
NAME OF PHYSICIAN (PRINT OR TYPE)	! <del></del>	<u> </u>	SIGNATURE C	. L OF PHYS	ician	
•			-			
REMARKS:			·· · · · · · · · · · · · · · · · · · ·			
				<del></del>		
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TH	RUE AND CORRECT		(SIGNATURE OF I	ENOLONE		
			(GIGNATURE OF I	EWLLO16	July 1	
AFPROVED TIME					11/10	
YES NO			(SIGNATURE OF	SUPERVIS	SOR)	
APPROVED YES NO	(SIGNATURE OF APPO	INTING AUT	ORITY OR AUT	HORIZE	DELEGATE	
						ļ
	<del></del>		<del></del>			





NOV 25 7015 1005 X 1005

NAME (FIRST, MIDDLE, LAST):	IDAYDOU NO.		- DEQUEATED		
NAME (PIRST, MIDDLE, LAST):	PAYROLL NO.:	DATI	E REQUESTED:		
JOHN PAUL MANUE	i		11/23	3/15	
TYPE OF LEAVE REQUESTED:					
SICK ANNUAL	MATERNITY E	EDUCATIONAL	MILITARY	JURY	OTHER
PAY STATUS:	HOURS:	(	) and 11/25		7-0.
W/PAY W/O PAY CO	MBINATION ,	W/PAY	W/OUT PA	AY	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH,	DAY, YEAR):		Charge Account I	NO:
11AM 11/23/15	12 PM 11	/23/15			10.
1 PM 11/23/15		1/2×15			· · · · · · · · · · · · · · · · · · ·
ADDRESS WHILE ON LEAVE:					
Hagatro	iau	· · · · · · · · · · · · · · · · · · ·			
	APPLICATION (	FOR PREPAYENT	OF VACATION LEAVE		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN	(10) CONSECUTIVE WORKING	DAYS. IT IS UNDER	STOOD THAT IF I RETUR	RN TO DUTY BEFORE	
THE EXPIRATION OF MY PREPAID VACATION, I SI PORTION OF THE PREPAID LEAVE.	HALL REIMBURSE THE GOVER	NMENT IN AN AMOL	NT EQUIVALENT TO TH	EUNEXPIRED	
IN COMPLIANCE WITH PERSONNEL RULES AND F		OF GLIAM IS ANY S		TONICE OF	
ILLNESS, INJURY, OR QUARANTINE IN EXCESS O	F THREE CONSECUTIVE WORK	KING DAYS, OR FOR	THE DAY IMMEDIATELY	BEFORE OR AFTER	
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, FURNISH A CERTIFICATION AS TO THE INCAPACI	TO BE GRANTED SICK LEAVE	THE GOVERNMENT	EMPLOYEE SHALL BE R	EQUIRED TO	
CERTIFICATION FOR SUCH OTHER PERIOD OF ILI	LNESS HE DEEMS ADVISABLE.	. IF THE CERTIFICAT	ION REQUIRED IS NOT I	FURNISHED, ALL	
ABSENCE WHICH WOULD HAVE BEEN COVERED	BY SUCH CERTIFICATION SHA	LL BE INDICATED O	N THE PAYROLL AS LEA	VE OF ABSENCE	
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE G		ICATION OF AN ILLN	ESS REPORT SHALL BE	CONSIDERED	
I CERTIFY THAT THE ABOVE NAMED PERSON WA	AS UNDER MY PROFESSIONAL	CARE OR QUARAN	TINED DURING THE PER	IOD STATED	
BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK,	HER CONDITION DURING THIS	S PERIOD WAS SUC	THAT I CONSIDERED I	TINADVISABLE	
	NTH, DAY, YEAR):	HOSPITALIZED?	NU	JMBER OF DAYS:	
		YES	□ NO		
					_
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGN	ATURE OF PHYSICI	AN	***
REMARKS:				····	<u> </u>
		<u> </u>		$\overline{\chi}$	······································
CERTIFY ALL STATEMENTS MADE HEREIN ARE	TRUE AND CORRECT	(SIGNA	TURE OP EMPLOYEE	d	
APPROVED YES NO				4 1-0	
		(SIGNA	TURE OF SUPERVISOR)	$\mathcal{N}\mathcal{N}$	ノ
APPROVED	(SIGNATURE OF APPOIN	TING ALITHORITY	OP ALITHORIZED DE	I ECATE\	
YES NO	foreigner of the fire	110101101110111111111111111111111111111	ON ACTIONIZED DE	LEGATE)	•
·					
***		-0-0			



# I LIHESLATURAN GUÅHAN GUAM LEGISLATURE 155 Hessler Place, Hagatna, Guam 96910

IUL 09 2015

JUL 09 2015

INSE (II S) James [

NAME (FIRST, MIDDLE, LAST): PAYROLL NO.:	DATE REQUESTED:
Joseph Anthony Mesnym	6/24/15
TYPE OF LEAVE REQUESTED:	
SICK ANNUAL MATERNITY EDUCATION	NAL MILITARY JURY OTHER
PAY STATUS: HOURS:	NA NA COLLOPE TILLE
W/PAY W/O PAY COMBINATION W/PAY	W/OUT PAY
FROM (HOUR, MONTH, DAY, YEAR): TO (HOUR, MONTH, DAY, YEA	R): CHARGE ACCOUNT NO.:
8Am July 02,2015 3pm July	
BRO Chy. Pale Ramon Yigo	·
APPLICATION FOR PRED	AYENT OF VACATION LEAVE
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) CONSECUTIVE WORKING DAYS. IT THE EXPIRATION OF MY PREPAID VACATION, I SHALL REIMBURSE THE GOVERNMENT IN PORTION OF THE PREPAID LEAVE.	IS UNDERSTOOD THAT IF I RETURN TO DUTY BEFORE AN AMOUNT EQUIVALENT TO THE UNEXPIRED
Programme and the contract of	
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAL	CERTIFICATION  A SE ANY EMPLOYEE IS ARREST DECAUSE OF
ILLINESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAY	S. OR FOR THE DAY IMMEDIATEL VISEGOE OF ACTED
IN HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVE	FRAMENT EMPLOYEE SHALL BE DECLIDED TO
FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSI CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE, IF THE C	CIAN. THE DEPARTMENT HEAD MAY REQUIRE
IMPOUNCE MAICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INT	BICATER ON THE DAVOOL I AS LEAVE OF ADSENCE
INTRODITION - SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF	F AN ILLNESS REPORT SHALL BE CONSIDERED
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVERNMENT SERVICE.  I CERTIFY THAT THE ABOVE NAMED PERSON WAS UNDER MY PROFESSIONAL CARE OF	
IBELOW: FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD	AQUARANTINED DURING THE PERIOD STATED  WAS SUCH THAT I CONSIDERED IT INADVISABLE
PROWING OR HER TO REPORT TO WORK.	
FROM (MONTH, DAY, YEAR): TO (MONTH, DAY, YEAR): HOSPITA	ALIZED? NUMBER OF DAYS:
	YES NO
NAME OF PHYSICIAN (PRINT OR TYPE)	
· · · · · · · · · · · · · · · · · · ·	SIGNATURE OF PHYSICIAN
REMARKS:	
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT	(SIGNATURE OF EMPLOYEE)
AFPROVED TO	1 9
YES NO	(SIGNATURE OF SUPERVISOR)
APPROVED (SIGNATURE OF APPOINTING AU	THORITY OR AUTHORIZED DELEGATE)
YES NO	· · · · · · · · · · · · · · · · · · ·
<u> </u>	

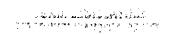


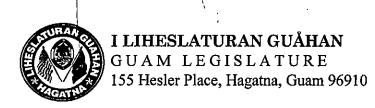
# I LIHESLATURAN GUÅHAN GUAM LEGISLATURE 155 Hessler Place, Hagatna, Guam 96910

GUAN LEGISLATURE PERSONNE PERSON OFFICE

JUL 23 2015

MANUTURED AUDOLG COM			NEC SEC	38 H:	
NAME (FIRST, MIDDLE, LAST): PAYROLL NO.:	DATE F	EQUESTED:		.,	
Joseph Anthony Mesnym		lo   24   IS			
TYPE OF LEAVE REQUESTED:		•			
SICK ANNUAL MATERNITY ED	UCATIONAL	MILITA	RY JURY		OTHER
PAY,STATUS: HOURS:		JM			
W/PAY W/O PAY COMBINATION W	1/PAY 3(3)	_ W/OUT	PAY	)	
FROM (HOUR, MONTH, DAY, YEAR): TO (HOUR, MONTH, D.	AY, YEAR).	<del>-</del>			
, , , , , , , , , , , , , , , , , , , ,	Tuly 16,2		original filed	I W/ P	PE 7-11-15
ADDOFSS WHILE ON LEAVE Pale Ramus Yigo					
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) CONSECUTIVE WORKING THE EXPIRATION OF MY PREPAID VACATION, I SHALL REIMBURSE THE GOVER PORTION OF THE PREPAID LEAVE.	RNMENT IN AN AMOU	STOOD THAT IF I NT EQUIVALENT	RETURN TO DUTY BEFORE TO THE UNEXPIRED	····	
				San San San	
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT	K LEAVE CERTIFIC FOF GUAM, IF ANY E	MPLOYEE IS ABS	ENT BECAUSE OF		
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WOF	RKING DAYS, OR FOR	THE DAY IMMED	ATEL Y BEFORE OR AFTER		İ
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENS	THE GOVERNMENT	EMPLOYEE SHAL	L BE REQUIRED TO		
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE	E. IF THE CERTIFICAT	ION REQUIRED IS	NOT FURNISHED, ALL		
ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SH	ALL BE INDICATED O	N THE PAYROLL	AS LEAVE OF ABSENCE		
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIF SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVERNMENT SERVICE.	FICATION OF AN ILLNI	ESS REPORT SHA	ALL BE CONSIDERED		
I CERTIFY THAT THE ABOVE NAMED PERSON WAS UNDER MY PROFESSIONA	L CARE OR QUARAN	TINED DURING T	HE PERIOD STATED		
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THE FROM HIS OR HER TO REPORT TO WORK.	IIS PERIOD WAS SUC	H THAT I CONSIE	ERED IT INADVISABLE		
EDOM (MONITH DAY ACTAD)	HOSPITALIZED?		NUMBER OF DAYS:	_	
	YES	Пио	, , , , , , , , , , , , , , , , , , , ,		
			ļ		
NAME OF PHYSICIAN (PRINT OR TYPE)	SIGNA	TURE OF PHY	SICIAN	· · · ·	
REMARKS:		<del></del>			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT	(SIGNAT	URE OF EMPLOY	THE PAL		,
APPROVED TYES TINO			1	···-	
	(SIGNA	TURE OF SUPERV	risoph		!
APPROVED YES NO (SIGNATURE OF APPOI	NTING AUTHORITY	OR AUTHORIZ	ED DELEGATE)		





NOV 25 2015

105 × 100 100

NAME (FIRST	, MIDDLE, LAST):		PAYROLL N	<u> </u>		IDATE DE	QUESTED		~		
	-		AINOLLI			DATER		,			
TYKEU	A S. MO	K)					11/2	3/15			
TYPE OF LEA	VE REQUESTED:										
SICK	ANNUAL	MA <sup>-</sup>	TERNITY	El	DUCATIO	NAL [	MILIT	TARY	JURY		OTHER
PAY STATUS:			H	lours:		<u> </u>	CARDICAN	11(2.5		····	
<b>★</b> W/PAY	W/O PAY	СОМВ	NOITAN	W	//PAY	_2		JT PAY	<del></del>		
FROM (HOUR	MONTH, DAY, YE	•	TO (HOUR, I		AY, YEAF 3 •   <b>5</b>	R):			Charge Account	NO:	
1700	11-23-15		1400	11- 8	13.15					· · · · · · · · · · · · · · · · · · ·	
								• "			
ADDRESS WH	ILE ON LEAVE:		•								
3000000000000		igatno	<u>lau</u>		908000000		<u></u>	000000000			
[*[*]*]*]*]*]*]*]*]*]*]*]		<u> </u>	APPL	ICATION FO	OR PREPA	YENT OF V	ACATION LE	AVE	<u> </u>		<u> </u>
	EMENT IS NOT LESS		CONSECUTIVE	WORKING I	DAYS. IT IS	UNDERSTO	DD THAT IF I F	ETURN TO DI			
THE EXPIRATION PORTION OF THE	OF MY PREPAID VAC. PREPAID LEAVE.	ATION, I SHALL	. REIMBURSE T	HE GOVERN	IMENT IN A	NAMOUNT E	QUIVALENT T	O THE UNEXF	PIRED		
IN COMPLIANCE V	VITH PERSONNEL RU	I ES AND RECI	II ATIONS GOV			ERTIFICAT		NT DECANCE	05		
	OR QUARANTINE IN I										
	END, DAY OFF, OR V										
	FICATION AS TO THE OR SUCH OTHER PER										
	WOULD HAVE BEEN										
	CK LEAVE PORTION				ATION OF	AN ILLNESS	REPORT SHA	L BE CONSID	ERED		
	E FOR DISMISSAL FF HE ABOVE NAMED PI				ARE OR O	JARANTINE	DURING THE	PERIOD STA	TED		
BELOW. FROM A	MEDICAL STANDPOI	NT, HIS OR HE									
FROM HIS OR HER FROM (MONTH	TO REPORT TO WO!		I, DAY, YEA	R): F	OSPITAL	IZED?		INUMBER	OF DAYS:		
,	,,	[					NO		. 01 2.110.		
					L., "	:s	NO				
NAME OF PHY	SICIAN (PRINT OI	R TYPE)	-	•		SIGNATU	RE OF PHY	SICIAN			<del>''' - ''</del>
REMARKS:							<del></del>			<del></del>	
										. 4	······································
								1)	[-dh-][	Mh :	
I CERTIFY ALL STA	ATEMENTS MADE HE	REIN ARE TRU	E AND CORREC	Э <b>Т</b>		(SIGNATURI	OF EMPLOY		fewer	LUBA	>>
APPROVED	YES	10				(SIGNATUR!	OF SUPERV	SOR)	M	1	
APPROVED,	YES I	10	SIGNATURE (	OF APPOIN	TING AUTH	ORITY OR	AUTHORIZE	D DELEGATI	E)	- 1	
, L											
											_



#### I LIHESLATURAN GUÅHAN GUAM LEGISLATURE 155 Hessler Place, Hagatna, Guam 96910

# GUAM LEGISLATURE PERSONNELIPAYONI OFFICE

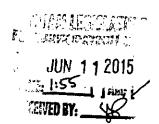
FEB 0.5 2015

TIME: 1:25 | JAN; | PH

			LEAV	E FOR				U	<u> </u>
NAME (FIRST, MIDDLE, LAST):		PAYROLL NO.:		DATE REQU					•
DANIEL D. PER	EZ	649240		1/	30/15	5			
TYPE OF LEAVE REQUESTED:				•					·
SICK ANNUAL	MA*	TERNITY E	EDUCATIO	NAL	MILITA	RY .	JURY		OTHER
PAY STATUS: W/PAY W/O PAY	СОМВІ	HOURS:	N/PAY	8) 2/4	15 X	PAY	-		
FROM (HOUR, MONTH, DAY, YE	AR):	TO (HOUR, MONTH, E	DAY, YEAR	t):	CHARGE A	CCOUNT NO.:			<u> </u>
8:00 a.m. 2/3/13	5	5:00 p.m. 3/	/ə/15					· · · · · · · · · · · · · · · · · · ·	
ADDRESS WHILE ON LEAV	/E:	421 TA	1616	AO, F	A GANA	HTS.			· · · · · · · · · · · · · · · · · · ·
		APPLICATIO	N FOR PRE	PAYENT OF VA	CATION LEAVE				
MINIMUM REQUIREMENT IS NOT LESS THE EXPIRATION OF MY PREPAID VACA PORTION OF THE PREPAID LEAVE.  IN COMPLIANCE WITH PERSONNEL RUILLNESS, INJURY, OR QUARANTINE IN E	LES AND REG	L REIMBURSE THE GOVE BULATIONS, GOVERNMENT HREE CONSECUTIVE WOF	RNMENT IN A SICK LEAV T OF GUAM, RKING DAYS	E CERTIFICATION OF ANY EMPLOYEE OR FOR THE DA	IVALENT TO THE  ON  E IS ABSENT BEC  Y IMMEDIATEL Y	UNEXPIRED  AUSE OF BEFORE OR AFTER	23.23.23.23		<u> </u>
A HOLIDAY, WEEKEND, DAY OFF, OR VI FURNISH A CERTIFICATION AS TO THE CERTIFICATION FOR SUCH OTHER PER ABSENCE WHICH WOULD HAVE BEEN O WITHOUT PAY. SICK LEAVE PORTION I SUFFICIENT CAUSE FOR DISMISSAL FR	INCAPACITY IOD OF ILLNE COVERED BY FOR TRIVIAL I OM THE GOV	FROM A REGULAR LICENS ESS HE DEEMS ADVISABLE SUCH CERTIFICATION SH INDISPOSITION, OR FALSI FERNMENT SERVICE.	SED PHYSICI E. IF THE CE. IALL BE INDIC FICATION OF	AN. THE DEPART RTIFICATION REC CATED ON THE P AN ILLNESS REI	MENT HEAD MAY QUIRED IS NOT FU AYROLL AS LEAV PORT SHALL BE C	REQUIRE JRNISHED, ALL E OF ABSENCE CONSIDERED		,	
CERTIFY THAT THE ABOVE NAMED PE BELOW. FROM A MEDICAL STANDPOIN	IT, HIS OR HE								
FROM (MONTH, DAY, YEAR):		H, DAY, YEAR):	HOSPITAL YI		NO	NUMBER OF DA	YS:	<u> </u>	<del></del>
NAME OF PHYSICIAN (PRINT OR	TYPE)			SIGNATURE	OF PHYSICIAN				·····
REMARKS:		<u></u>	<u>.</u>					<del></del>	
1 CERTIFY ALL STATEMENTS MADE HER	REIN ARE TRI	UE AND CORRECT		(SIGNATURE OF	EMPLOYEE)	Janoit 1	- Su		
APPROVED YES N				(SIGNATURE OF			VANE	SSA-ME	NO
APPROVED YES N		SIGNATÜRE OF APPOIN	NTING AUTH	IORITY OR AUT	HÖRIZED DELE	GATE)			



#### I LIHESLATURAN GUÅHAN GUAM LEGISLATURE 155 Hessler Place, Hagatna, Guam 96910



	LEA	A TO Y. OXCOL			
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTE			
DANIEL D. PEREZ	647248	6/11/1	5 🛒	-	
TYPE OF LEAVE REQUESTED:					
SICK ANNUAL MA	TERNITY EDUCATIO	NAL	MILITARY	JURY	OTHER
PAY STATUS:	HOURS:	- 101	1/12/15		
WIPAY WIO PAY COMBI	NATION . W/PAY	4) * `	W/OUT PAY	<u> </u>	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR	R):	HARGE ACCOUNT NO	<i>:</i>	
8:00 A.m. 4/11/15	12:00 P.M. 6/11	/15			
ADDRESS WHILE ON LEAVE:	<u></u>				
4;	71 TA1616AO.	AGANA H	TS.		
	APPLICATION FOR PRE	FRAYENT OF VACATI	ONIFAVE		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (1	0) CONSECUTIVE WORKING DAYS, IT I	IS UNDERSTOOD THAT	IF I RETURN TO DUTY BEFO	PRE	
THE EXPIRATION OF MY PREPAID VACATION, I SHA PORTION OF THE PREPAID LEAVE.	LL REIMBURSE THE GOVERNMENT IN	AN AMOUNT EQUIVALE	INT TO THE UNEXPIRED		
		VE CERTIFICATION			
IN COMPLIANCE WITH PERSONNEL RULES AND RE					
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TA HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO	==	•		TER	
FURNISH A CERTIFICATION AS TO THE INCAPACITY CERTIFICATION FOR SUCH OTHER PERIOD OF ILLN					
ABSENCE WHICH WOULD HAVE BEEN COVERED BY	Y SUCH CERTIFICATION SHALL BE INDI	CATED ON THE PAYRO	LL AS LEAVE OF ABSENCE		
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL SUFFICIENT CAUSE FOR DISMISSAL FROM THE GO	•	F AN ILLNESS REPORT	SHALL SE CONSIDERED		
I CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR H					
FROM HIS OR HER TO REPORT TO WORK					
FROM (MONTH, DAY, YEAR): TO (MONT	TH, DAY, YEAR): HOSPITAI	LIZED?	NUMBER OF	DAYS:	
		ES NO	F		
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF P	HYSICIAN		
REMARKS:					
		T			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TO	RUE AND CORRECT	(SIGNATURE OF EMPI	LOYES and	Dall	
APPROVED YES NO		(SIGNATURE OF SUPE		NAE VANESSA M	ENO
APPROVED YES NO	(SIGNATURE OF APPOINTING AUT	HORITY OR AUTHOR	IZED DELEGATE)	1 1	<del></del>
				1	
L.					



GUAM LEGISLATURE

JUN 25 2015 1222 251 JAN; 17 ECEIPED BY: 12

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	LEAV	DATE REQUEST	red:		<u>-</u>							
DANIEL D. PEREZ	643340		6/2	3/15:1									
DANIEL D. FUNEL	64 90 10			7/13/2									
TYPE OF LEAVE REQUESTED:	<u> </u>												
	ATERNITY ED	DUCATION		MILITARY		JURY		OTHER					
SICK ANNUAL M	AIEMNITY L	JUCATION	NOL		<u> </u>	JUKT	ш	OTHER					
PAY STATUS:	HOURS:			00 (0)	2-1.1								
W/PAY W/O PAY COMBINATION W/PAY 8 VB WOUT PAY													
	' "		عقد	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•	_							
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DA	AY, YEAR	1):	CHARGE ACC	OUNT NO.:								
21. 2.2.1/21/15	500 P.M. 61	1501	· ·										
8:00 A.M. 6/24/15	1240 KAIL 61	1 24/	15				·····						
	<u> </u>		····	<u> </u>									
ADDRESS WHILE ON LEAVE:			A (1 1A	بهستدا ا									
	421 TA1616	6AU	H GANT	H >-		1000000000	inanaeee	10111111111111111111					
	APPLICATION	FOR PRE	PAYENT OF VACA	TION LEAVE			<u>100010000</u>	<u> </u>					
MINIMUM REQUIREMENT IS NOT LESS THAN TEN	* *												
THE EXPIRATION OF MY PREPAID VACATION, I SH PORTION OF THE PREPAID LEAVE.	ALL REIMBURSE THE GOVER	INMENT IN A	AN AMOUNT EQUIVA	LENT TO THE UNI	EXPIRED								
955555555555555555555555555555555555							2000	68 98 88 88 88 88 88 88 88 88 88 88 88 88					
<u> </u>							<del></del>	SICK LEAVE CERTIFICATION					
IN COMPLANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ASSENT SECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY SEFORE OR AFTER													
						R	-						
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, 1	THREE CONSECUTIVE WORLD BE GRANTED SICK LEAVE	KING DAYS	OR FOR THE DAY I	MMEDIATEL Y BEJ ! SHALL, BE REQU	ORE OR AFTE	7							
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, T FURNISH A CERTIFICATION AS TO THE INCAPACIT	THREE CONSECUTIVE WOR! TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENS!	KING DAYS THE GOVE ED PHYSICI	, OR FOR THE DAY II RNMENT EMPLOYEE IAN, THE DEPARTME	MMEDIATEL Y SEJ ! SHALL BE REQU ENT HEAD MAY RE	ORE OR AFTE RED TO QUIRE	₹	•						
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, 1	THREE CONSECUTIVE WOR! TO BE GRANTED SICK LEAVE "Y FROM A REGULAR LICENS! NESS HE DEEMS ADVISABLE	KING DAYS THE GOVE ED PHYSICI IF THE CE	, OR FOR THE DAY!! RIMENT EMPLOYEE IAN, THE DEPARTME RTIFICATION REQUI	MMEDIATEL Y BEJ ! SHALL BE REQU !NT HEAD MAY RE RED IS NOT FURN	ORE OR AFTE RED TO QUIRE ISHED, ALL,	<b>R</b>	·						
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, T FURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED I WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TO FROM A REGULAR LICENSE NESS HE DEEMS ADVISABLE. BY SUCH CERTIFICATION SHA IL INDISPOSITION, OR FALSIFE	KING DAYS THE GOVE ED PHYSICI IF THE CE ALL SE INDR	, OR FOR THE DAY!! RNMENT EMPLOYEE IAN, THE DEPARTME ERTIFICATION REQUI CATED ON THE PAY	MMEDIATEL, Y SEJ ! SHALL BE REQUI !NT HEAD MAY RE RED IS NOT FURN ROLL AS LEAVE O	ORE OR AFTE RED TO QUIRE ISHED, ALL, IF ABSENCE	<b>R</b>							
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, T FURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED I	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TO FROM A REGULAR LICENSE NESS HE DEEMS ADVISABLE. BY SUCH CERTIFICATION SHA LINDISPOSITION, OR FALSIFI OVERNMENT SERVICE.	KING DAYS, THE GOVE ED PHYSICI I, IF THE CE ALL, BE INDI ICATION OF	, OR FOR THE DAY! RNMENT EMPLOYEE IAN, THE DEPARTME RTIFICATION REQUI CATED ON THE PAY: F AN ILLNESS REPO	MMEDIATEL Y SEI ! SHALL BE REQUI !NT HEAD MAY RE RED IS NOT FURN ROLL AS LEAVE O RT SHALL BE CON	ORE OR AFTE RED TO QUIRE ISHED, ALL F ABSENCE SIDERED	<b>R</b>							
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED IS WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE GICERTRY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR	THREE CONSECUTIVE WORU TO BE GRANTED SICK LEAVE "Y FROM A REQUAR LICENSI NIESS HE DEEMS ADVISABLE IN SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI DVERNMENT SERVICE, S UNDER MY PROFESSIONAL	KING DAYS, THE GOVER ED PHYSICS IF THE CE ALL SE INDICATION OF	, OR FOR THE DAY II RNMENT EMPLOYEE IAN, THE DEPARTME RTIFICATION REQUI CATED ON THE PAY: F AN ILLNESS REPO QUARANTINED OUR	MMEDIATEL, Y SEJ 5 SHALL, BE REQUI ENT HEAD MAY RE RED IS NOT FURN ROLL AS LEAVE O RIT SHALL BE CON ING THE PERSOD	TORE OR AFTE: RED TO QUIRE ISHED, ALL, F ABSENCE SIDERED								
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, THE FUNDER A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABBEING WHICH WOULD HAVE BEEN COVERED IN WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL, FROM THE GOOD CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW, FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVER ED PHYSICS IF THE CE ALL SE INDICATION OF	OR FOR THE DAY II RNMENT EMPLOYEE IAN, THE DEPARTME IRTIFICATION REQUI CATED ON THE PAY. F AN ILLNESS REPOI QUARANTINED DUR WAS SUCH THAT I C	MMMEDIATEL, Y BEJ 5 SHALL BE REQUI ENT HEAD MAY RE RED 18 NOT FURN ROLL AS LEAVE O RIT SHALL BE CON SING THE PERSOD ONSIDERED IT RU	TORE OR AFTE: RED TO QUIRE ISHED, ALL, F ABSENCE SIDERED								
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, THE FUNDER A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABBEING WHICH WOULD HAVE BEEN COVERED IN WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL, FROM THE GOOD CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW, FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI LIFTHE CE ALL SE INDI GCATION OF L CARE OR LS PERSOD Y	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME RETIFICATION REQUI CATED ON THE PAY. F AN ILLNESS REPOI QUARANTINED OUR WAS SUCH THAT I C	MMEDIATEL, Y BEJ  2 SHALL, BE REQUI  NT HEAD MAY RE  ROLL AS LEAVE O  RT SHALL BE CON  ING THE PERSOD  ONSIDERED IT RU  NU	ORE OR AFTE; RED TO QUIRE ISHED, ALL, # ABBENCE; SIDERED STATED								
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, THE FUNDER A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABBEING WHICH WOULD HAVE BEEN COVERED IN WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL, FROM THE GOOD CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW, FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI LIFTHE CE ALL SE INDI GCATION OF L CARE OR LS PERSOD Y	OR FOR THE DAY II RNMENT EMPLOYEE IAN, THE DEPARTME IRTIFICATION REQUI CATED ON THE PAY. F AN ILLNESS REPOI QUARANTINED DUR WAS SUCH THAT I C	MMEDIATEL, Y BEJ  2 SHALL, BE REQUI  NT HEAD MAY RE  ROLL AS LEAVE O  RT SHALL BE CON  ING THE PERSOD  ONSIDERED IT RU  NU	ORE OR AFTE; RED TO QUIRE ISHED, ALL, # ABBENCE; SIDERED STATED		· · · · · · · · · · · · · · · · · · ·						
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED IS WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE GICERTRY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR):  TO (MON	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI LIFTHE CE ALL SE INDI GCATION OF L CARE OR LS PERSOD Y	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME RETIFICATION REQUI CATED ON THE PAY. F AN ILLNESS REPOI QUARANTINED OUR WAS SUCH THAT I C	MMMEDIATEL, Y BEJ  2 SHALL BE REQUI  NOT HEAD MAY RE  RED IS NOT FURN  ROLL AS LEAVE O  RT SHALL BE CON  ONSIDERED IT INV.  NU.	ORE OR AFTE; RED TO QUIRE ISHED, ALL, # ABBENCE; SIDERED STATED		· · · · · · · · · · · · · · · · · · ·						
ILLNESS, INJURY, OR QUARANTINÈ IN EXCESS OF A HOLIDAY, WEEKEND, DAY GFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED IS WITHOUT PAY, SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE GITCENTRY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MONTH) DAY, YEAR):	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI LIFTHE CE ALL SE INDI GCATION OF L CARE OR LS PERSOD Y	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME PRITIFICATION REQUI CATED ON THE PAY. F AN ILLNESS REPOI QUARANTINED DUR WAS SUCH THAT I C LIZED?	MMMEDIATEL, Y BEJ  2 SHALL BE REQUI  NOT HEAD MAY RE  RED IS NOT FURN  ROLL AS LEAVE O  RT SHALL BE CON  ONSIDERED IT INV.  NU.	ORE OR AFTE; RED TO QUIRE ISHED, ALL, # ABBENCE; SIDERED STATED								
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY GFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED IS WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE GICERTRY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MON	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI LIFTHE CE ALL SE INDI GCATION OF L CARE OR LS PERSOD Y	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME PRITIFICATION REQUI CATED ON THE PAY. F AN ILLNESS REPOI QUARANTINED DUR WAS SUCH THAT I C LIZED?	MMMEDIATEL, Y BEJ  2 SHALL BE REQUI  NOT HEAD MAY RE  RED IS NOT FURN  ROLL AS LEAVE O  RT SHALL BE CON  ONSIDERED IT INV.  NU.	ORE OR AFTE; RED TO QUIRE ISHED, ALL, # ABBENCE; SIDERED STATED								
ILLNESS, INJURY, OR QUARANTINÈ IN EXCESS OF A HOLIDAY, WEEKEND, DAY GFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED IS WITHOUT PAY, SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE GITCENTRY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MONTH) DAY, YEAR):	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI LIFTHE CE ALL SE INDI GCATION OF L CARE OR LS PERSOD Y	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME PRITIFICATION REQUI CATED ON THE PAY. F AN ILLNESS REPOI QUARANTINED DUR WAS SUCH THAT I C LIZED?	MMMEDIATEL, Y BEJ  2 SHALL, BE REQUI  NOT HEAD MAY RE  RED IS NOT FURN  ROLL AS LEAVE O  RT SHALL BE CON  ONSIDERED IT INV.  NU.	ORE OR AFTE; RED TO QUIRE ISHED, ALL, # ABBENCE; SIDERED STATED								
ILLNESS, INJURY, OR QUARANTINÈ IN EXCESS OF A HOLIDAY, WEEKEND, DAY GFF, OR VACATION, TEURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED IS WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE GICERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MONTH OR TYPE)  REMARKS:	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI LIFTHE CE ALL SE INDI GCATION OF L CARE OR LS PERSOD Y	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME IAN, THE DEPARTME IAN THE DEPARTME IAN ILLNESS REPOIL GUARANTINED DUR WAS SUCH THAT I C LIZED?  ES NO SIGNATURE OF	MMMEDIATEL, Y SEJ  1 SHALL, BE REQUI  NOT HEAD MAY RE  RED IS NOT FUR  ROLL AS LEAVE O  RT SHALL BE CON  ING THE PERSOD  ONSIDERED IT RU  ONSI	ORE OR AFTE; RED TO QUIRE ISHED, ALL, # ABBENCE; SIDERED STATED	AYS:							
ILLNESS, INJURY, OR QUARANTINÈ IN EXCESS OF A HOLIDAY, WEEKEND, DAY GFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED IS WITHOUT PAY, SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE GITCENTRY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MONTH) DAY, YEAR):	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI LIFTHE CE ALL SE INDI GCATION OF L CARE OR LS PERSOD Y	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME PRITIFICATION REQUI CATED ON THE PAY. F AN ILLNESS REPOI QUARANTINED DUR WAS SUCH THAT I C LIZED?	MMMEDIATEL, Y SEJ  1 SHALL, BE REQUI  NOT HEAD MAY RE  RED IS NOT FUR  ROLL AS LEAVE O  RT SHALL BE CON  ING THE PERSOD  ONSIDERED IT RU  ONSI	ORE OR AFTE; RED TO QUIRE ISHED, ALL, # ABBENCE; SIDERED STATED								
ILLNESS, INJURY, OR QUARANTINÈ IN EXCESS OF A HOLIDAY, WEEKEND, DAY GFF, OR VACATION. TEURNISH A CERTIFICATION AS TO THE INCAPACITIC CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED IS WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAS SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOALD INCOME. TO BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MONTH).  NAME OF PHYSICIAN (PRINT OR TYPE)  REMARKS:	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI LIFTHE CE ALL SE INDI GCATION OF L CARE OR LS PERSOD Y	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME IAN, THE DEPARTME IAN THE DEPARTME IAN ILLNESS REPOIL GUARANTINED DUR WAS SUCH THAT I C LIZED?  ES NO SIGNATURE OF	MMMEDIATEL, Y SEJ  1 SHALL, BE REQUI  NOT HEAD MAY RE  RED IS NOT FUR  ROLL AS LEAVE O  RT SHALL BE CON  ING THE PERSOD  ONSIDERED IT RU  ONSI	ORE OR AFTE; RED TO QUIRE ISHED, ALL, # ABBENCE; SIDERED STATED	AYS:							
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY GFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED IS WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE GICERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MON NAME OF PHYSICIAN (PRINT OR TYPE)  REMARKS:	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI LIFTHE CE ALL SE INDI GCATION OF L CARE OR LS PERSOD Y	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME IAN, THE DEPARTME IAN THE DEPARTME IAN ILLNESS REPOIL GUARANTINED DUR WAS SUCH THAT I C LIZED?  ES NO SIGNATURE OF	MMEDIATEL, Y SEI  SHALL BE REQUI  NT HEAD MAY RE RED IS NOT FURN ROLL AS LEAVE O  RT SHALL BE CON  ONSIDERED IT HA  PHYSICIAN  APLOYEE)	ORE OR AFTE; RED TO QUIRE ISHED, ALL, # ABBENCE; SIDERED STATED	AYS:							
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY GFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED IS WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE GICERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MON NAME OF PHYSICIAN (PRINT OR TYPE)  REMARKS:	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI LIFTHE CE ALL SE INDI GCATION OF L CARE OR LS PERSOD Y	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME PRIFICATION REQUIL CATED ON THE PAY, F AN ILLNESS REPOIL QUARANTINED DUR WAS SUCH THAT I C LIZED?  ES NO SIGNATURE OF EN	MMEDIATEL, Y SEI  SHALL BE REQUI  NT HEAD MAY RE RED IS NOT FURN ROLL AS LEAVE O  RT SHALL BE CON  ONSIDERED IT HA  PHYSICIAN  APLOYEE)	ORE OR AFTE. RED TO QUIRE ISHED, ALL F ABBENCE SIDERED  MATATED LOWISABLE  MBER OF D.	AYS:	*	ENO					
ILLNESS, INJURY, OR QUARANTINÈ IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL MITHOUT PAY, SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE OIL CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MONING INCAPACITY OF THE COMMON INCAPACI	THREE CONSECUTIVE WORD TO BE GRANTED BICK LEAVE TY FROM A REQUIAR LICENSI NY SUCH CERTIFICATION SHA L. INDISPOSITION, OR FALSIF OVERNMENT SERVICE, S UNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI ED	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE PAY INTERPORT INTO IT IN	MMMEDIATEL, Y SEJ SHALL BE REQUINT HEAD MAY RE REGUL AS LEAVE O RT SHALL BE CON ING THE PERSOD ONSIDERED IT RU  PHYSICIAN  APLOYEE  JPERVISOR)	RENN	AYS:	*	ENO					
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY GFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED IS WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE GICERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MON NAME OF PHYSICIAN (PRINT OR TYPE)  REMARKS:	THREE CONSECUTIVE WORD TO BE GRANTED SICK LEAVE TY FROM A REGULAR LICENSI NESS HE DEEMS ADVISABLE. SY SUCH CERTIFICATION SHA L INDISPOSITION, OR FALSIFI OVERNMENT SERVICE. SUNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI ED	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE PAY INTERPORT INTO IT IN	MMMEDIATEL, Y SEJ SHALL BE REQUINT HEAD MAY RE REGUL AS LEAVE O RT SHALL BE CON ING THE PERSOD ONSIDERED IT RU  PHYSICIAN  APLOYEE  JPERVISOR)	RENN	AYS:	*	ENO					
ILLNESS, INJURY, OR QUARANTINÈ IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL MITHOUT PAY, SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE OIL CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MONING INCAPACITY OF THE COMMON INCAPACI	THREE CONSECUTIVE WORD TO BE GRANTED BICK LEAVE TY FROM A REQUIAR LICENSI NY SUCH CERTIFICATION SHA L. INDISPOSITION, OR FALSIF OVERNMENT SERVICE, S UNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI ED	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE PAY INTERPORT INTO IT IN	MMMEDIATEL, Y SEJ SHALL BE REQUINT HEAD MAY RE REGUL AS LEAVE O RT SHALL BE CON ING THE PERSOD ONSIDERED IT RU  PHYSICIAN  APLOYEE  JPERVISOR)	RENN	AYS:	*	ENO					
ILLNESS, INJURY, OR QUARANTINÈ IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL MITHOUT PAY, SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL, FROM THE OIL CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW, FROM A MEDICAL STANDPOINT, HIS OR FROM INS ON HER TO REPORT TO WORK.  FROM (MONTH, DAY, YEAR): TO (MONING INCAPACITY OF THE COMMON INCAPAC	THREE CONSECUTIVE WORD TO BE GRANTED BICK LEAVE TY FROM A REQUIAR LICENSI NY SUCH CERTIFICATION SHA L. INDISPOSITION, OR FALSIF OVERNMENT SERVICE, S UNDER MY PROFESSIONAL HER CONDITION DURING THE	KING DAYS, THE GOVE ED PHYSICI ED	OR FOR THE DAY II RIMMENT EMPLOYEE IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE DEPARTME IAN, THE PAY INTERPORT INTO IT IN	MMMEDIATEL, Y SEJ SHALL BE REQUINT HEAD MAY RE REGUL AS LEAVE O RT SHALL BE CON ING THE PERSOD ONSIDERED IT RU  PHYSICIAN  APLOYEE  JPERVISOR)	RENN	AYS:	*	ENO					

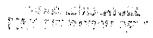


		LEAV	E FORM				
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:		DATE REQUEST	ED:			
DANIEL D. PEREZ	643340		4/30	115 11			
TYPE OF LEAVE REQUESTED:				· · · · · · · · · · · · · · · · · · ·	<del></del>		
SICK ANNUAL M	ATERNITY E	EDUCATION	7AL	MILITARY	JURY		THER
PAY STATUS:	HOURS:	-	210	۱۹			-
W/PAY W/O PAY COME	INATION ; · \	N/PAY (	3) 100	(S & WIOUTPAY			
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, I	DAY, YEAR	):	CHARGE ACCO	UNT NO.:		
1:00 P.M. 6/30/15 /	12:00 b.W.	1/1/16		,			
ADDRESS WHILE ON LEAVE:	() 21 ±0	-L C L C A	A / A				
	न्त्र ।	(G)GA	o, AGAN	M H15.			
	ARRI ICATIO	N EOB BRE	PAYENT OF VACA	TION I FAVE			
MINIMUM REQUIREMENT IS NOT LEGS THAN TEN				<del></del>	XITY BEFORE		
THE EXPIRATION OF MY PREPAID VACATION, I SH PORTION OF THE PREPAID LEAVE.	ALL REIMBURSE THE GOVE	RNMENT IN	IN AMOUNT EQUIVA	LENT TO THE UNEX	PIRED		
PORTION OF THE PROPERTY.			<del> </del>	<del></del>			
IN COMPLIANCE WITH PERSONNEL RULES AND R	FOUR ATTOMS CONTRACTOR		E CERTIFICATION		tor		
ILLNESS, INJURY, OR QUARANTINÈ IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, I FURNISH A CERTIFICATION AS TO THE INCAPACII CERTIFICATION FOR SUCH OTHER PERIOD OF ILL ABSENCE WHICH WOULD HAVE BEEN COVERED! WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE G	TO BE GRANTED SICK LEAV TY FROM A REGULAR LICEN NEBS HE DEEMS ADVISABL BY SUCH CERTIFICATION SI LL INDISPOSITION, OR FALS	'E THE GOVE IBED PHYSIC! .E. IF THE CE HALL, BE INDX	RIMENT EMPLOYER AN. THE DEPARTME RTIFICATION REQUI CATED ON THE PAY	E SHALL BE REQUIR ENT HEAD MAY REQ RED IS NOT FURNIS ROLL AS LEAVE OF	ED TO UIRE HED, ALL ABSENCE		
I CERTIFY THAT THE ABOVE NAMED PERSON WA	A UNDER MY PROFESSION						
BELOW: FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK	HER CONDITION DURING T	HIS PERSOO V	VAS SUCH THAT I C	ONSIDERED IT INAL	WISABLE		
	TH, DAY, YEAR):	HOSPITAL	IZED?	NUN	IBER OF DAYS:		
		│ □ʏ	ES N	o			
NAME OF PHYSICIAN (PRINT OR TYPE)			SIGNATURE OF	PHYSICIAN			
REMARKS:							
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)							
APPROVED YES NO			(SIGNATURE OF SI			ESSA MEN	0
APPROVED YES NO	(SIGNATURE OF APPOI	INTING AUT	HORITY OR AUTH	ORIZED DELEGAT			

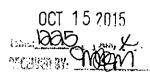


# COMMUNICATION OF THE STREET

•	LEA	/E FORM		
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:		
DANIEL D. PEREZ	642240	7/15/15		
TYPE OF LEAVE REQUESTED:				
SICK ANNUAL MA	TERNITY EDUCATIO	NAL MILITARY	JURY	OTHER
PAY STATUS:	HOURS:	18 7 23/15		
W/PAY W/O PAY COMBI	NATION WIPAY	Wenter	? <u></u>	٠
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEA	CHARGE ACC	OUNT NO.:	
8:00 a.m. 7/15/15	12:00P.M. 7/16/15			
ADDRESS WHILE ON LEAVE:	4124	A C 4 10 11-5 c		•
***************************************	421 TAIGIGHO,	H 6/WH (+1 > 1		
		EPAYENT OF VACATION LEAVE		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (1 THE EXPIRATION OF MY PREPAID VACATION, I SHA PORTION OF THE PREPAID LEAVE.				\$3555555555555555555555555555555555555
FURNISH A CERTIFICATION AS TO THE INCAPACITY CERTIFICATION FOR SUCH OTHER PERIOD OF ILLA ASSENCE WHICH WOULD HAVE SEEN COVERED BY WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL SUFFICIENT CAUSE FOR DISMISSAL FROM THE OC	HESS HE DEEMS ADVISABLE, IF THE C Y BUCH CERTIFICATION SHALL BE INC , INDISPOSITION, OR FALSIFICATION C TYPERMIENT SERVICE.	ERTIFICATION REQUIRED IN NOT FURN ICATED ON THE PAYROLL AS LEAVE OF IF AN ILLNESS REPORT SHALL SE CON	SHED, ALL, FABSENCE SIOERED	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
I CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR !				
FROM HIS OR HER TO REPORT TO WORK. FROM (MONTH, DAY, YEAR): TO (MONTH)	TH, DAY, YEAR): HOSPITA	LIZED? NO NU	MBER OF DAYS:	
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	··-·,_ ··· · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·
REMARKS:				
I CERTIFY ALL STATEMENTS MADE HEREIN ARE T	RUE AND CORRECT	(SIGNATURE OF EMPLOYEE)	aniel 4	14
APPROVED YES NO		(SIGNATURE OF SUPERVISOR)	RENNARVAL	ESSA MENO
				/ 2







· · · · · ·		LEAV	E FORM				
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	- Ic	ATE REQUEST	ED;			
DANIEL D. PEREZ	64334	0	10/5	115	<i>.</i>		
TYPE OF LEAVE REQUESTED:						•	
SICK ANNUAL M	ATERNITY	EDUCATION	u	MILITA	RY JUR	Υ 🔲	OTHER
PAY STATUS:	HOURS	/		7			
W/PAY W/O PAY COMI	IINATION 3	W/PAY (	Te/ki/k	> W/OUT	PAY		
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH,	DAY, YEAR)		CHARGE A	vccount no.:	•	
8 a.m. 10/5/15	9 a.m. 1	0/5/1	5				
Address while on leave:	<u> </u>						
	4>1 TA1	616 Az	, A-61	m/+ 1	HTS,		
200000000000000000000000000000000000000	APPLICATI	ON POR PRE	AYENT OF VACA	TION LEAVE	939393939393939393939 		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN	(10) CONSECUTIVE WORLD	NO DAYS, IT IS	UNDERSTOOD THE	IT IF I RETUR	N TO DUTY BEFORE		
THE EXPIRATION OF MY PREPAID VACATION, I SI PORTION OF THE PREPAID LEAVE.	HALL REIMBURSE THE GOV	ERNAMENT IN A	N AMOUNT BUILVA		UNEONED		
98888888888888888888888888888888888888			CERTIFICATION				
FURNISH A CERTIFICATION AS TO THE INCAPACE CERTIFICATION FOR SUCH OTHER PERIOD OF E. ABBENCE WHICH WOULD HAVE BEEN COVERED WITHOUT FAY. SICK LEAVE FORTION FOR TRIVIAL CERTIFY THAT THE ABOVE NAMED PERSON W. BELOW. FROM A BENCHAL STANDFORT, HIS OF	inèse he dèsins advisae ey such certification s al incisposition, or fal dovernment service. As under my propession	ILE. IF THE CEI HALL BE INCK BIFICATION OF UAL CARE OR (	ITIFICATION REIGHI ATED ON THE PAY AN ILLHIBB REPO	RED IO NOT P ROLL, AS LEAY RT SHALL BE ING THE PER	UNNIGHES, ALL VE OF ABBENCE CONBIDERED IOD STATED		<del></del>
PROM HIS OR HIR TO REPORT TO WORK	NTH, DAY, YEAR):	HOSPITAL	7507		NUMBER OF DAYS		w
FROM (MONTH, DAY, YEAR): TO (MO	NII, UAI, IBAN		:s	· 3 -	* DATE	•	
NAME OF PHYSICIAN (PRINT OR TYPE)	<u> </u>	<u></u>	SIGNATURE OF	PHYSICIA	N		
REMARKS							
I CERTIFY ALL, STATEMENTS MADE HERRIN ARE	THUE AND CORRECT		(SIGNATURE OF EI	PLOYED (	Daniel &	Por	
APPROVED YES NO			(CICHATURE OF SE			VANESSAN	ŒNO
APPROVED YES NO	(SIGNATURE OF APPR		HORITY OR AUTH	ORIZEO DEL	EGATE)	00	
	<del></del>	<del>-\</del>	()				<u> </u>



GUAM LEGISLATURE PERSONNEL PAYROLL OFFICE

MAY 0 4 2015 T. 1:00 | JAM | / | RECEIVED BY: NA

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:
	0==<0	
Wilfred T. Pinzon	97762	April 27, 2015
TYPE OF LEAVE REQUESTED:	·	workman's comp
SICK X ANNUAL MAT	ERNITY EDUCATION	AL MILITARY JURY OTHER
PAY STATUS:	HOURS:	
X W/PAY W/O PAY COMBI	NATION W/PAY	8hrs W/OUT PAY
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR)	CHARGE ACCOUNT NO.:
8:00am April 27, 2015	5:00pm April 27	v, 2015
ADDRESS WHILE ON LEAVE: 92 San	Miguel St. Talofofo, C	Juam
	was well and the second of the	
	APPLICATION FOR PREPA	YENT OF VACATION LEAVE
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10	) CONSECUTIVE WORKING DAYS, IT IS I	INDERSTOOD THAT IF I RETURN TO DUTY BEFORE
THE EXPIRATION OF MY PREPAID VACATION, I SHAL PORTION OF THE PREPAID LEAVE.	L REIMBURSE THE GOVERNMENT IN AN	I AMOUNT EQUIVALENT TO THE UNEXPIRED
		ERTIFICATION
IN COMPLIANCE WITH PERSONNEL RULES AND REGI	JLATIONS, GOVERNMENT OF GUAM, IF	ANY EMPLOYEE IS ABSENT BECAUSE OF
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TH	REE CONSECUTIVE WORKING DAYS, OF	FOR THE DAY IMMEDIATELY BEFORE OR AFTER
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO FURNISH A CERTIFICATION AS TO THE INCAPACITY F	BE GRANTED SICK LEAVE THE GOVERN	MENT EMPLOYEE SHALL BE REQUIRED TO
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES		
ABSENCE WHICH WOULD HAVE BEEN COVERED BY S		
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL		
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE		
I CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR I	S UNDER MY PROFESSIONAL CARE OR HER CONDITION DURING THIS PERIOL	QUARANTINED DURING THE PERIOD STATED  D WAS SUCH THAT I CONSIDERED IT INADVISABLE
FROM HIS OR HER TO REPORT TO WORK.		
FROM (MONTH, DAY, YEAR): TO (MONTH	I, DAY, YEAR): HOSPITALI	ZED? NUMBER OF DAYS:
	YE	S NO
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN
REMARKS:		
REWARD.		
CERTIFY ALL STATEMENTS MADE HEREIN ARE T	RUE AND CORRECT	(SIGNATURE OF EMPLOYEE)
		1 ( ) ( ) TO
APPROVED		Welf of my
YES NO		(SIGNATURE OF SUPERVISOR)
APPROVED YES NO	SIGNATURE OF APPOINTING AUTHO	PRITY OR AUTHORIZED DELEGATE)
<u> </u>	( )	<i>f</i>
	James 9	X. hying
		<del></del>

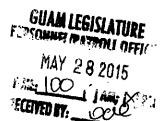


#### GUAM LEGISLATURE FERSONNEL PAYROLI OFFICE

MAY 28 2015

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.;	DATE REQUESTED:		
Pinzon, Wilfred	97762	May 28, 2	015	
TYPE OF LEAVE REQUESTED:		•	•	СТО
SICK ANNUAL MAT	ERNITY EDUCATION	IAL MILIT	ARY JURY	OTHER
PAY STATUS:	HOURS:	1)5/29/15	5	
W/PAY W/O PAY COMBI	NATION W/PAY	Zhrs. WOU	T PAY	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR	CIERROL	ACCOUNT NO.:	
8am 5/20/15	5pm 5/20/15	8hrs	Sick	
<b>≇12m</b> 5/26/15	4pm 5/26/15	3 4hrs	annual	
ADDRESS WHILE ON LEAVE: 92 San	Miguel St., Talofofo G	Juam	·	
WALL OF A PROTEIN	APPLICATION FOR PREPA			
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10 THE EXPIRATION OF MY PREPAID VACATION, I SHAL PORTION OF THE PREPAID LEAVE.	•			
	SICK LEAVE (	CERTIFICATION		
IN COMPLIANCE WITH PERSONNEL RULES AND REGI			BECAUSE OF	
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TH A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO				
FURNISH A CERTIFICATION AS TO THE INCAPACITY I			*	
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES		-	•	· \$
ABSENCE WHICH WOULD HAVE BEEN COVERED BY WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL				
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE				
I CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.	HER CONDITION DURING THIS PERIO			
FROM (MONTH, DAY, YEAR): TO (MONTI	H, DAY, YEAR): HOSPITAL	IZED?	NUMBER OF DAYS:	
	Y	ES NO		
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSI	CIAN	
		·		
REMARKS:				
I CERTIFY ALL STATEMENTS MADE HEREIN ARE T	TRUE AND CORRECT	(SIGNATURE OF EMPLOYED	E)	
APPROVED YES NO		(SIGNATURE OF SUPERVIS	1 hyung	
APPROVED YES NO	(SIGNATURE OF APPOINTING AUTH	ORITY OR AUTHORIZED	DELEGATE)	
	My him	ŋ		
		-	<del></del>	





NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:	
Pinzon, Wilfred	97762	May 28, 2015	
TYPE OF LEAVE REQUESTED:	· · · · · · · · · · · · · · · · · · ·		СТО
SICK ANNUAL MAT	ERNITY EDUCATION	AL MILITARY	JURY OTHER
PAY STATUS:	HOURS:	6129/15	
W/PAY W/O PAY COMBI	NATION W/PAY	.hrs.DCLL	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR)	: CHARGE ACCOUNT NO.	:
1pm 5/28/15	4pm 5/28/15	3 A hrs ANNUAL	
8am 5/29/15	5pm 5/29/15	8 hrs ANNUAL	
ADDRESS WHILE ON LEAVE: 92 San	Miguel St., Talofofo G	uam	
		YENT OF VACATION LEAVE	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10 THE EXPIRATION OF MY PREPAID VACATION, I SHAL PORTION OF THE PREPAID LEAVE.	•		
	SICK LEAVE (	ERTIFICATION	
IN COMPLIANCE WITH PERSONNEL RULES AND REGI			
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TH			FTER
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO FURNISH A CERTIFICATION AS TO THE INCAPACITY I		*	_:
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES		-	
ABSENCE WHICH WOULD HAVE BEEN COVERED BY S WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL			
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE	ERNMENT SERVICE.		
I CERTIFY THAT THE ABOVE NAMED PERSON WAS BELOW. FROM A MEDICAL STANDPOINT, HIS OR I			
FROM (MONTH, DAY, YEAR): TO (MONTI	H, DAY, YEAR): HOSPITAL	ZED? NUMBER OF I	DAYS:
	YE		
		• <u> </u>	
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE T	RUE AND CORRECT	(SIGNATURE OF EMPLOYEE)	· ·
<u> </u>		Wife Tan	
APPROVED YES NO		(SIGNATURE OF SUPERVISOR)	Impury
APPROVED YES NO	SIGNATURE OF APPOINTING AUTH	PRITY OR AUTHORIZED DELEGATE)	
	U )		,
	Theme or 1	V.	
		- (* · )	



GHAM LEGISLATURE

# **LEAVE FORM**

JUL 23 2015

NAME OF THE OWN ASSESSMENT OF THE OWN	DAMBOLL NO	DATE DEGLEGRED				
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:	0/3			
Wilfred T. Pinzon	97762	July 17, 2015				
TYPE OF LEAVE REQUESTED:			cto			
SICK X ANNUAL MAT	ERNITY EDUCATION	IAL MILITARY	JURY X OTHER			
PAY STATUS:	HOURS:	- 12111170	.llts			
X W/PAY W/O PAY COMBI	NATION W/PAY	8hrs W/OUT PAY	4HRS CTO 4HRS ANNUAL			
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR)	<u>,                                      </u>				
row (nook, wonth, DAT, 1EAK).	TO (HOUR, MONTH, DAT, TEAR)	CHARGE ACCO	UNT NO.:			
8:00am July 17, 2015	5:00pm July 17,	2015				
	th San Miguel St. Talofo					
ATHUR THE DESCRIPTION OF THE PROPERTY OF		YENT OF VACATION LEAVE	O NUME DEPOND			
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10 THE EXPIRATION OF MY PREPAID VACATION, I SHAI PORTION OF THE PREPAID LEAVE.						
The second secon	<del></del>					
IN COMPLIANCE WITH PERSONNEL RULES AND REG		ERTIFICATION	/ NE OF			
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THAT A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO FURNISH A CERTIFICATION AS TO THE INCAPACITY	REE CONSECUTIVE WORKING DAYS, OI BE GRANTED SICK LEAVE THE GOVERN	R FOR THE DAY IMMEDIATELY BEI IMENT EMPLOYEE SHALL BE REQU	FORE OR AFTER JIRED TO			
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES			-			
ABSENCE WHICH WOULD HAVE BEEN COVERED BY WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVI	INDISPOSITION, OR FALSIFICATION OF					
I CERTIFY THAT THE ABOVE NAMED PERSON WA		R QUARANTINED DURING THE PE	RIOD STATED			
BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.						
FROM (MONTH, DAY, YEAR): TO (MONT	H, DAY, YEAR): HOSPITAL	IZED? NUM	BER OF DAYS:			
		ES NO				
NAME OF PHYSICIAN (PRINT OR TYPE) SIGNATURE OF PHYSICIAN						
REMARKS:						
I CERTIFY ALL STATEMENTS MADE HEREIN ARE	I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)					
Well Thing						
APPROVED YES NO (SIGNATURE OF SUPERVISOR)						
APPROVED (SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)						
	YES NO CHANGE OF A TOMAN OF A TOM					



### GHAN LEGISLATURE FEXSORIU PATRICI AFFICE

JUL 23 2015

THE LOS I FAME | JPM
SECRIFORY: 40

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:			
Wilfred T. Pinzon	97762	July 20, 201	5		
TYPE OF LEAVE REQUESTED:	<u> </u>		•	cto	
SICK X ANNUAL MA	TERNITY EDUCATION	NAL MILITAR	Y JURY	OTHER	
PAY STATUS:	HOURS:	7/24/15			
X W/PAY W/O PAY COMB	INATION W/PAY (	6hrs W/OUT P	AY		
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR	): CHARGE AC	COUNT NO.:		
10:00am July 20, 2015	4:00pm July 20,	, 2015	•		
ADDRESS WHILE ON LEAVE: 243 No.	rth San Miguel St. Talofo	ofo, Guam	"		
2000	ADDITION FOR BRED	VENT OF VACATION LEAD	<b>T</b>	D <sub>e</sub> et e 14,8 Mai a	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (I		AYENT OF VACATION LEAV UNDERSTOOD THAT IF I RETUR			
THE EXPIRATION OF MY PREPAID VACATION, I SHA PORTION OF THE PREPAID LEAVE.		······································	· · · · · · · · · · · · · · · · · · ·		
	SICK LEAVE	CERTIFICATION		<u> Parking Andrews (Angles Angles (Angles >	
IN COMPLIANCE WITH PERSONNEL RULES AND REC					
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TO A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO					
FURNISH A CERTIFICATION AS TO THE INCAPACITY	FROM A REGULAR LICENSED PHYSICIA	N. THE DEPARTMENT HEAD MA	Y REQUIRE		
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNE ABSENCE WHICH WOULD HAVE BEEN COVERED BY					
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL					
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOV I CERTIFY THAT THE ABOVE NAMED PERSON WA		D ALIADANTINED DIIDINA TUE	DEDIOD STATED		
BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.					
	H, DAY, YEAR): HOSPITAL	IZED?	UMBER OF DAYS:		
		'ES NO			
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIA	AN		
REMARKS:		¥***	707 700		
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT  (SIGNATURE OF EMPLOYEE)  WHO Therefore the statements of the statement of the statements of the statement of the statements of the statement of th					
APPROVED YES NO		(SIGNATURE OF SUPERVISOR)	Ulmay	•	
APPROVED YES NO	(SIGNATURE OF APPOINTING AUTH	ORITY OR AUTHORIZED DEL	EGATE)		
	Volumo g.	bryen			



MGATTI	LE	EAVE FORM	AUG 20	2015 /
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:	, FOR	A 4730 13
, , ,			SCEIVED BY:	TAKESOT
WILFRED TPINTON	97762	8-13-1		
TYPE OF LEAVE REQUESTED:				
SICK ANNUAL MAT	ERNITY EDU	CATIONAL MILITARY	JURY	OTHER
PAY STATUS:	HOURS:	( (SOMO 87E):	/ <u>~</u>	<del></del> -
W/PAY W/O PAY COMB		PAY W/OUT PAY	· · · · · · · · · · · · · · · · · · ·	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY	, YEAR): CHARGE ACCO	OUNT NO.:	
7AL 8-13-15	11Am 8-13-	-15		
ADDRESS WITH COLUMN	<u></u>	<u></u>		
ADDRESS WHILE ON LEAVE:  92 San Miguel 94	TALOFOFO L	Fuam 96915		
		R PREPAYENT OF VACATION LEAVE		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10 THE EXPIRATION OF MY PREPAID VACATION, I SHAI PORTION OF THE PREPAID LEAVE.	) CONSECUTIVE WORKING DA	YS. IT IS UNDERSTOOD THAT IF I RETURN T		
	SICK I	LEAVE CERTIFICATION		•
IN COMPLIANCE WITH PERSONNEL RULES AND REG ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF TH A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO FURNISH A CERTIFICATION AS TO THE INCAPACITY CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNES ABSENCE WHICH WOULD HAVE BEEN COVERED BY WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVE	IREE CONSECUTIVE WORKING BE GRANTED SICK LEAVE THE FROM A REGULAR LICENSED P. SS HE DEEMS ADVISABLE. IF TR SUCH CERTIFICATION SHALL B INDISPOSITION, OR FALSIFICA	DAYS, OR FOR THE DAY IMMEDIATELY BE GOVERNMENT EMPLOYEE SHALL BE REQ HYSICIAN. THE DEPARTMENT HEAD MAY I BE CERTIFICATION REQUIRED IS NOT FURN BE INDICATED ON THE PAYROLL AS LEAVE	FORE OR AFTER UIRED TO REQUIRE IISHED, ALL OF ABSENCE	
CERTIFY THAT THE ABOVE NAMED PERSON WA BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.		<del>-</del>		
· · · · · · · · · · · · · · · · · · ·	H, DAY, YEAR):	SPITALIZED? NUM	IBER OF DAYS:	<del></del>
		YES NO		
NAME OF PHYSICIAN (PRINT OR TYPE)	<u> </u>	SIGNATURE OF PHYSICIAN		
REMARKS:				
CERTIFY ALL STATEMENTS MADE HEREIN ARE 1	FRUE AND CORRECT	(SIGNATURE OF EMPLOYEE)	7.	
APPROVED YES NO		(SIGNATURE OF SUPERVISOR)	Spring	
APPROVED YES NO	(SIGNATURE OF APPOINTING	G AUTHORITY OR AUTHORIZED DELEC	GATE)	



GUAN LEGISLATUPE PERSONNE PAYROLL OFFICE

APR 0 3 2015

NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:				
Tricia Ann S. Pocaigue	97792	March 31, 20	15			
TYPE OF LEAVE REQUESTED:			CTD			
X SICK X ANNUAL MA	TERNITY EDUCATIO	NAL MILITAR				
PAY STATUS:	HOURS:	<b>Эсто</b>	11 0-15			
X W/PAY W/O PAY COME	INATION W/PAY	16 8 Sick	Wours Cit			
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR	₹);	Charge Account NO:			
8am, Mar.27, 2015	5pm, Mar.30, 2015	1	J 3			
		,				
ADDRESS WHILE ON LEAVE:		<u> </u>				
127 RB 0	Quitaro St. Yona, Guam 96	915				
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10	APPLICATION FOR PREPA		The state of the s			
THE EXPIRATION OF MY PREPAID VACATION, I SHAUPORTION OF THE PREPAID LEAVE.						
		CERTIFICATION				
IN COMPLIANCE WITH PERSONNEL RULES AND REG			T BECAUSE OF			
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF T A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO						
FURNISH A CERTIFICATION AS TO THE INCAPACITY						
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNE			•			
ABSENCE WHICH WOULD HAVE BEEN COVERED BY WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL						
SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOV	ERNMENT SERVICE.					
I CERTIFY THAT THE ABOVE NAMED PERSON WAS I BELOW. FROM A MEDICAL STANDPOINT, HIS OR HE						
FROM HIS OR HER TO REPORT TO WORK.						
FROM (MONTH, DAY, YEAR): TO (MONT	H, DAY, YEAR): HOSPITAL	"ISED."	NUMBER OF DAYS:			
	YI	ES NO				
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSIC	CIAN			
REMARKS:			1000			
	,					
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE) Tricia Cux S. Tocaigne						
APPROVED VES INO			00			
[Z] 1E3	YES NO (SIGNATURE OF SUPERVISOR)					
APPROVED YES NO	SIGNATURE OF APPOINTING AUT	HORITY OR AUTHORIZED	DELEGATE			
			1 / /			
<del></del>						



MAY 28 2015
THE 1127 IN Am; 1 184
ECEIVED BY: 120

NAME (FIRST	r, MIDDLE, LAST):	PAYROLL NO.:	IDATE REQUESTED:			
1		1	1 1			
Tricia	Pocalque	a+7-92	5/21/15			
TYPE OF LEA	IVE REQUESTED:					
SICK	X ANNUAL MA	TERNITY EDUCAT	TIONAL MILITA	ARY JURY OTHER		
PAY STATUS		HOURS:	5 5 DQ	15		
★ W/PAY	W/O PAY COME	BINATION W/PAY	_3) Wood	PAY		
FROM (HOUR	I, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YI	EAR):	Charge Account NO:		
# 2pm	May 29, 2015	5pm May 2	912015	Sharge Assourt No.		
	<del></del>	7				
ADDRESS WI	HILE ON LEAVE:	8 Chalan Sai	n Antonio	suite 101 Tam, 96913		
			7 Table 1 Table 1 Table 1 Table 1 Table 1	A. 10		
MINIMUM REQUI	REMENT IS NOT LESS THAN TEN (1	0) CONSECUTIVE WORKING DAYS.	PAYENT OF VACATION LE	RETURN TO DUTY BEFORE		
THE EXPIRATION PORTION OF THE	I OF MY PREPAID VACATION, I SHA PREPAID LEAVE.	LL REIMBURSE THE GOVERNMENT	IN AN AMOUNT EQUIVALENT	TO THE UNEXPIRED		
2.86.34			E CERTIFICATION			
IN COMPLIANCE	WITH PERSONNEL RULES AND RE	BULATIONS, GOVERNMENT OF GU	AM, IF ANY EMPLOYEE IS ABSE	ENT BECAUSE OF		
ILLNESS, INJURY A HOLIDAY, WEE	, OR QUARANTINE IN EXCESS OF 1 KEND, DAY OFF, OR VACATION, TO	THREE CONSECUTIVE WORKING DA	YS, OR FOR THE DAY IMMEDI	ATELY BEFORE OR AFTER		
FURNISH A CERT	TRICATION AS TO THE INCAPACITY	FROM A REGULAR LICENSED PHY	SICIAN. THE DEPARTMENT HE	AD MAY REQUIRE		
CERTIFICATION F	FOR SUCH OTHER PERIOD OF ILLN I WOULD HAVE BEEN COVERED BY	ESS HE DEEMS ADVISABLE, IF THE	CERTIFICATION REQUIRED IS	NOT FURNISHED, ALL		
WITHOUT PAY. S	SICK LEAVE PORTION FOR TRIVIAL	INDISPOSITION, OR FALSIFICATION	NOF AN ILLNESS REPORT SHA	ALL BE CONSIDERED		
	SE FOR DISMISSAL FROM THE GO THE ABOVE NAMED PERSON WAS		OR CHARANTINED DURING TH	E BERIOD STATED		
BELOW. FROM A	MEDICAL STANDPOINT, HIS OR H	ER CONDITION DURING THIS PERIC	D WAS SUCH THAT I CONSIDE	RED IT INADVISABLE		
	R TO REPORT TO WORK. H, DAY, YEAR): TO (MONT	H, DAY, YEAR): HOSPIT	ALIZED?	NUMBER OF DAYS:		
			YES NO			
NAME OF PHY	SICIAN (PRINT OR TYPE)		SIGNATURE OF PHYS	ICIAN		
REMARKS:						
SIGNATURE OF EMPLOYEE)  THE CONTROL OF EMPLOYEE  STATEMENTS MADE HEREIN ARE TRUE AND CORRECT  (SIGNATURE OF EMPLOYEE)  STATEMENTS MADE HEREIN ARE TRUE AND CORRECT  (SIGNATURE OF EMPLOYEE)						
APPROVED	YES NO					
(SIGNATURE OF SUPERVISOR)						
APPROVED (SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)						
1	YES NO					
				4-7		

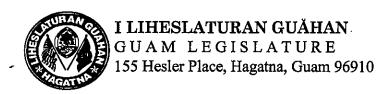


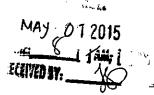
NAME (FIRST MIDDLE LAST)	IOAN/DOLL NO					
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:				
Tricia Pocaique	97792	7/13/15				
TYPE OF LEAVE REQUESTED:						
X SICK X ANNUAL MA	TERNITY EDUCATIO	NAL MILITARY	JURY OTHER			
PAY STATUS:	HOURS:	DUCK-24 hr				
W/PAY W/O PAY COME	BINATION W/PAY	56 HOLIDAY 8 Annual - Ho				
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR	3): 272	Charge Account NO:			
8am July 01, 2015	5pm July 10,201	5 5	Charge Account No.			
3	J					
ADDRESS WHILE ON LEAVE:						
FHP Health	Center / 107 1	7B Quitaro St.	Yona Gu.			
		YENT OF VACATION LEAVE				
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (1)	O) CONSECUTIVE WORKING DAYS, IT IS	S UNDERSTOOD THAT IF I RETURN TO	DUTY BEFORE			
THE EXPIRATION OF MY PREPAID VACATION, I SHAI PORTION OF THE PREPAID LEAVE,						
		ERTIFICATION				
IN COMPLIANCE WITH PERSONNEL RULES AND REC	BULATIONS, GOVERNMENT OF GUAM,	IF ANY EMPLOYEE IS ABSENT BECAUS	E OF			
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF T A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO						
FURNISH A CERTIFICATION AS TO THE INCAPACITY CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNI						
ABSENCE WHICH WOULD HAVE BEEN COVERED BY						
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOV		FAN ILLNESS REPORT SHALL BE CONS	IDERED			
I CERTIFY THAT THE ABOVE NAMED PERSON WAS	UNDER MY PROFESSIONAL CARE OR (					
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HI FROM HIS OR HER TO REPORT TO WORK.	ER CONDITION DURING THIS PERIOD W	AS SUCH THAT I CONSIDERED IT INAD	VISABLE			
	H, DAY, YEAR): HOSPITAL	IZED? NUMBER	OF DAYS:			
	YE	s No				
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF BUNGIOLAN				
NAME OF FRESIDIAN (FAINT OR TTPE)		SIGNATURE OF PHYSICIAN				
REMARKS:						
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE) Frica Course						
APPROVED YES NO						
(SIGNATURE OF SUPERVISOR)						
APPROVED (SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)						
YES NO						
		7				



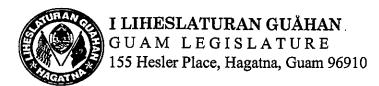
# GUAM LEGISLATURE PERCENNAM MAYORITI OFFICE

			<u> </u>				
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:					
Tricia Pocaique	97752	7/23/15					
TYPE OF LEAVE REQUESTED:							
SICK X ANNUAL MATERNITY DEDUCATIONAL MILITARY JURY OTHER							
PAY STATUS:	HOURS:	C 40 =	rhalie.				
★ W/PAY  W/O PAY  COM	BINATION W/PAY	(8) WOUT	7 23 15 PAY				
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YE	AR):	Charge Account NO:				
8am 7 22 2015	5pm 7/22/20	15	onarge Account No.				
	110010						
ADDRESS WHILE ON LEAVE:		1					
1	27 RB Quitarc		Gu.				
		AYENT OF VACATION LEA					
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (	0) CONSECUTIVE WORKING DAYS, IT	IS UNDERSTOOD THAT IF I RI	ETURN TO DUTY BEFORE				
THE EXPIRATION OF MY PREPAID VACATION, I SHA PORTION OF THE PREPAID LEAVE.	LL REIMBURSE THE GOVERNMENT II	AN AMOUNT EQUIVALENT TO	O THE UNEXPIRED				
<u> </u>							
IN COMPLIANCE WITH PERSONNEL RULES AND RE	·	CERTIFICATION  I. IF ANY EMPLOYEE IS ABSEN	NT BECAUSE OF				
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF	THREE CONSECUTIVE WORKING DAY	S, OR FOR THE DAY IMMEDIA	TELY BEFORE OR AFTER				
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO FURNISH A CERTIFICATION AS TO THE INCAPACITY	BE GRANTED SICK LEAVE THE GOV	ERNMENT EMPLOYEE SHALL I	BE REQUIRED TO				
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLA	ESS HE DEEMS ADVISABLE, IF THE C	CIAN, THE DEPARTMENT HEAT ERTIFICATION REQUIRED IS N	D MAY HEQUIHE NOT FURNISHED. ALL				
ABSENCE WHICH WOULD HAVE BEEN COVERED BY	SUCH CERTIFICATION SHALL BE INT	CATED ON THE PAYROLL AS	LEAVE OF ABSENCE				
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL SUFFICIENT CAUSE FOR DISMISSAL FROM THE GO		OF AN ILLNESS REPORT SHAL	L BE CONSIDERED				
I CERTIFY THAT THE ABOVE NAMED PERSON WAS		QUARANTINED DURING THE	PERIOD STATED				
BELOW. FROM A MEDICAL STANDPOINT, HIS OR H							
FROM HIS OR HER TO REPORT TO WORK. FROM (MONTH, DAY, YEAR): TO (MONTH)	TH, DAY, YEAR): HOSPITA	N IZED2	NUMBER OF DAYS:				
()		<del></del>	NOWIDER OF DATS.				
		YES   NO					
NAME OF PHYSICIAN (PRINT OR TYPE)	<u> </u>	SIGNATURE OF PHYSI	CIAN				
REMARKS:							
	<del></del>						
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE) Trucia Cur & Pocarga							
APPROVED — U							
YES NO (SIGNATURE OF SUPERVISOR)							
APPROVED (SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)							
YES NO							
			7 /				
			( / )				





NAME (FIRST, MIDDLE, LAST):	IPAYROLL NO.:	DATE REQUESTED:			
	PATROLL NO	DATE REGUESTED:			
Agnes B. Rumbaoa	97778	April 20, 20	15		
TYPE OF LEAVE REQUESTED:	<u> </u>	<del></del>			
SICK 🖾 ANNUAL 🗌 MA	TERNITY EDUCATION	DNAL MILITA	RY JURY OTHER		
PAY STATUS:	HOURS:	2/1/2			
X W/PAY W/O PAY COME	BINATION W/PAY	8 SW/OUT	PAY		
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEA	NR):	Charge Account NO:		
8:00 am 04/28/15	5:00 pm 04/28/15	.[			
ADDRESS WHILE ON LEAVE: 276 Littl	e Manila Finile Drive Aga	, Guam			
	ADDI ICATION FOR PRED	WENT OF MAGATION & FAN			
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (	10) CONSECUTIVE WORKING DAYS, I	VENT OF VACATION LEAVERSTOOD THAT IF I	RETURN TO DUTY BEFORE		
THE EXPIRATION OF MY PREPAID VACATION, I SHA PORTION OF THE PREPAID LEAVE.	ALL REIMBURSE THE GOVERNMENT I	N AN AMOUNT EQUIVALENT	TO THE UNEXPIRED		
	SICK I FAVE	CERTIFICATION			
IN COMPLIANCE WITH PERSONNEL RULES AND RE			ENT BECAUSE OF		
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO					
FURNISH A CERTIFICATION AS TO THE INCAPACITY	Y FROM A REGULAR LICENSED PHYS	ICIAN. THE DEPARTMENT HE	AD MAY REQUIRE		
CERTIFICATION FOR SUCH OTHER PERIOD OF ILLN ABSENCE WHICH WOULD HAVE BEEN COVERED BY					
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL	INDISPOSITION, OR FALSIFICATION	OF AN ILLNESS REPORT SHA	ALL BE CONSIDERED		
SUFFICIENT CAUSE FORDISMISSAL FROM THE GO I CERTIFY THAT THE ABOVE NAMED PERSON WAS		P OHADANTINED OHDING T	JE DEDIOD CTATED		
BELOW. FROM A MEDICAL STANDPOINT, HIS OR F					
FROM (MONTH, DAY, YEAR): TO (MONT	TH, DAY, YEAR): HOSPITA	LIZED?	NUMBER OF DAYS:		
, , , , , , , , , , , , , , , , , , , ,			TOMBER OF BATO.		
	\\	ES NO			
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN			
REMARKS:					
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)					
APPROVED -	<del> </del>	<u></u>	Agnes B. Rumbaoa		
YES NO	OR)				
APPROVED LYES LING	(SIGNATURE OF APPOINTING AUT	HORITY OR AUTHORIZED	DELEGATE)		
L TES NO	YES NO				
			<del></del>		
			( )		

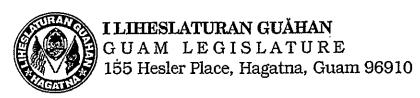


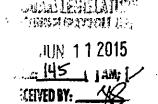
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:		DATE REQUESTED:			
HAME (FRS1, WIDDLE, CAS1).	PATROLL NO		DATE REQUESTED:			
Agnes B. Rumbaoa	97778		July 29, 20	15		
TYPE OF LEAVE REQUESTED:						
SICK X ANNUAL MATERNITY EDUCATIONAL MILITARY JURY OTHER						
PAY STATUS:	HOURS:		V \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	N 08-08-12		
X W/PAY W/O PAY COM	BINATION	W/PAY	42 (B) W/OUT	<del>•</del> -		
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, 5:00 pm 07/3		IR):	Charge Account NO:		
V 42 411 04130/16	3.00 pin 0770	31713				
ADDRESS WHILE ON LEAVE:	<u> </u>					
276 Litt	le Manila Finile Dr	r. Agat, G	iuam 96928			
MINIMUM REQUIREMENT IS NOT LESS THAN TEN			YENT OF VACATION LEA			
THE EXPIRATION OF MY PREPAID VACATION, I SH PORTION OF THE PREPAID LEAVE.						
	<u> </u>	CV LEAVE	CERTIFICATION			
IN COMPLIANCE WITH PERSONNEL RULES AND RI				ENT BECAUSE OF		
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF						
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, T FURNISH A CERTIFICATION AS TO THE INCAPACIT						
CERTIFICATION FOR SUCH OTHER PERIOD OF ILL	NESS HE DEEMS ADVISAE	BLE. IF THE C	ERTIFICATION REQUIRED	S NOT FURNISHED, ALL		
ABSENCE WHICH WOULD HAVE BEEN COVERED B WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIA						
SUFFICIENT CAUSE FORDISMISSAL FROM THE GO	OVERNMENT SERVICE.					
I CERTIFY THAT THE ABOVE NAMED PERSON WA BELOW. FROM A MEDICAL STANDPOINT, HIS OR FROM HIS OR HER TO REPORT TO WORK.						
FROM (MONTH, DAY, YEAR): TO (MON	TH, DAY, YEAR):	HOSPITA	LIZED?	NUMBER OF DAYS:		
			ES NO			
NAME OF BUNCHOLAN (BRINT OR TYPE)	<u> </u>					
NAME OF PHYSICIAN (PRINT OR TYPE)			SIGNATURE OF PHYS	ICIAN		
REMARKS:						
4 20						
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)  Acries B. Rumbaca						
APPROVED THE				1		
YES NO		(SIGNATURE OF SUPERVIS	SOR)			
APPROVED YES NO	(SIGNATURE OF APPOI	NTING AUT	ORITY OR AUTHORIZED	DELEGATE)		
YES NO						
				$\sim$ $/$		



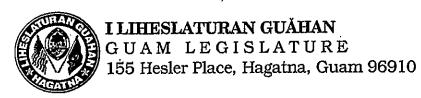
AND INTEREST WERE.

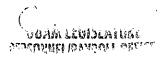
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	<del></del>	DATE REQUESTED:		
	0-1-1				
Unseph San Agustin	97710		10-1-15		
TYPE OF LEAVE REQUESTED:				•	СТО
SICK ANNUAL M	ATERNITY	EDUCATION	JAL MILIT	TARY JURY	OTHER
PAY STATUS:	HOUR	S: , ,	$\sim$ $\sim$ $\sim$ $\sim$ $\sim$ $\sim$ $\sim$ $\sim$ $\sim$ $\sim$		
W/PAY W/O PAY COM	IBINATION	W/PA	that mals wou	JT РАҮ	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONT)	I, DAY, YEAR	): CHARGE	ACCOUNT NO.:	
1pm 9-25-15	5pm 9.	-25-15			
·	1 '				
ADDRESS WHILE ON LEAVE:					
107 Thomas St. Tav	nuning				
MINIMUM REQUIREMENT IS NOT LESS THAN TEN			YENT OF VACATION L		
THE EXPIRATION OF MY PREPAID VACATION, I SH PORTION OF THE PREPAID LEAVE.	• •				
		CTCSC T TO A STOR O	TENNING A PRINCE		
IN COMPLIANCE WITH PERSONNEL RULES AND RE			CERTIFICATION  ANY EMPLOYEE IS ABSENT	T BECAUSE OF	
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF	THREE CONSECUTIVE WO	RKING DAYS, O	R FOR THE DAY IMMEDIAT	ELY BEFORE OR AFTER	
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, T					
FURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILLA					
ABSENCE WHICH WOULD HAVE BEEN COVERED B	Y SUCH CERTIFICATION S	HALL BE INDICA	TED ON THE PAYROLL AS	LEAVE OF ABSENCE	
WITHOUT PAY, SICK LEAVE PORTION FOR TRIVIA SUFFICIENT CAUSE FOR DISMISSAL FROM THE GO		LSIFICATION OF.	AN ILLNESS REPORT SHALL	L BE CONSIDERED	
I CERTIFY THAT THE ABOVE NAMED PERSON W		IONAL CARE OF	QUARANTINED DURING	THE PERIOD STATED	<del></del>
BELOW. FROM A MEDICAL STANDPOINT, HIS O	R HER CONDITION DURI	ng teus perio	WAS SUCH THAT I CONS	SIDERED IT INADVISABLE	
FROM HIS OR HER TO REPORT TO WORK. FROM (MONTH, DAY, YEAR): TO (MON	TH, DAY, YEAR):	HOSPITAL	ZED2	NUMBER OF DAYS:	·
	7	—	<del></del>	NOMBLE OF DATS.	1
	'	∐YE	S NO		
NAME OF PHYSICIAN (PRINT OR TYPE)	<del>'</del>		SIGNATURE OF PHYSI	ICIAN	
REMARKS:					
·					<del> </del>
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)					
(SIGNATURE OF ENTLOTEE)					
APPROVED YES NO		,			
		ļ	SIGNATURE OF SUPERVIS	DR) Shan Beach	ce
APPROVED	(SIGNATURE OF APPO	INTING AUTHO	RITY OR AUTHORIZED	DELEGATE)	
YES NO					
				,	' ]
			•		
<del></del>	<del></del>		<del> </del>	<del></del>	





NAME (FIRST, MIDDLE, LAST):	IPAYROLL NO.:		DATE REQUESTED:		
ROMLIO TEEHAN . JP.			٧	iuhe 11, 201	۷
TYPE OF LEAVE REQUESTED:				*	
SICK ANNUAL MA	ATERNITY E	DUCATIO	NAL MILITA	RY JURY	OTHER
PAY STATUS:	HOURS:		(10-1	L,L	
W/PAY W/O PAY COM	NOITANIE	V/PAY	(16) HRS WOUT	PAY	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH,	DAY, YEAF	₹);	Charge Account N	10:
JUNE 10 , 2015	JUNE 11,	2015		5, m. 35, m. s.	, •••
		•			- · · · · · · · · · · · · · · · · · · ·
	<u> </u>				
ADDRESS WHILE ON LEAVE:	·				
TALATA	FO, GUA-M	_			
(1)**(\$126年6545+(5])**(31656(5)(5)(31668(8))*b					PROFITE OF A SERVICE SERVICE
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (			YENT OF VACATION LEA		· · · · · · · · · · · · · · · · · · ·
THE EXPIRATION OF MY PREPAID VACATION, I SHA PORTION OF THE PREPAID LEAVE.					
Markovitetti elikeristen komende				un Krailina ana an	对中国共和国共和国共和国共和国共和国共和国共和国共和国共和国共和国共和国共和国共和国
IN COMPLIANCE WITH PERSONNEL RULES AND RE			CERTIFICATION  JE ANY EMPLOYEE IS ABSE	NT RECAUSE OF	
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF	The second secon				
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO					
FURNISH A CERTIFICATION AS TO THE INCAPACIT CERTIFICATION FOR SUCH OTHER PERIOD OF ILL					
ABSENCE WHICH WOULD HAVE BEEN COVERED B	Y SUCH CERTIFICATION SH	IALL BE INDI	CATED ON THE PAYROLL A	S LEAVE OF ABSENCE	
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL SUFFICIENT CAUSE FOR DISMISSAL FROM THE GO		FICATION O	F AN ILLNESS REPORT SHA	LL BE CONSIDERED	
CERTIFY THAT THE ABOVE NAMED PERSON WAS		L CARE OR	QUARANTINED DURING TH	PERIOD STATED	
BELOW. FROM A MEDICAL STANDPOINT, HIS OR I					
FROM (MONTH, DAY, YEAR): TO (MON	TH, DAY, YEAR):	HOSPITA	LIZED?	NUMBER OF DAYS:	
			<del></del>		
		L_  <sup>*</sup>	ES NO	ı	
NAME OF PHYSICIAN (PRINT OR TYPE)			SIGNATURE OF PHYSICIAN .		
REMARKS:					
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)					
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)					
APPROVED TYES TNO			(Alaxive per of all province	^	A
		(SIGNATURE OF SUPERVIS	Li Li		
APPROVED (SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)					
YES NO				,	
·					





NOV 25 2015

TECHYED BY DOLD

NAME (FIR	ST, MIDDLE, I	LAST):		PAYROLL	NO.:	<del></del>	DATE RE	QUESTED:		<del></del>		
		•							_			
KONSKO								1000 . D	5,2	01<		
TYPE OF L	EAVE REQUE	STED:	`									_
SICH	SICK ANNUAL MATERNITY EDUCATIONAL MILITARY JURY OTHER											
PAY STATE	JS:				HOURS:			111-25	77.7			
W/P	W/PAY W/O PAY COMBINATION W/PAY W/OUT PAY											
FROM (HO	UR, MONTH, I	DAY, YE	AH):	TO (HOUR	, MONTH,	DAY, YEA	7):			Charge Account	<b>VO:</b>	
8 WW	NOU . I	e120	K	SIRM	NOU	15,70	Ķ					
				- 4								-
	<del> </del>											
ADDRESS	WHILE ON LE	AVE:		, <u>.</u>		1 111	<u> </u>			<u> </u>		
		TA	vapor	ъ								
\$19 <b>\$</b> 000\$46	cheactin, Park		以代表中華							(Pagewalda) (Alba	darqueda;	>16.4(S)(\$74 <u>\$</u> 2 <b>5</b> \$9)?
MINIMUM REC	QUIREMENT IS N	OT LESS 1	THAN TEN (1					VACATION LE		DUTY BEFORE	<del> </del>	
THE EXPIRAT	ION OF MY PREF THE PREPAID LE	AID VACA	NTION, I SHA	LL REIMBURS	E THE GOVI	ERNMENT IN	AN AMOUNT	EQUIVALENT 1	TO THE UNE	EXPIREO		
MOST SOLD	場所が組みという	1975 (44)	学的学术的	26/24/45 B)		CK LEAVE				Market Property and	经存储额证据	APPENTANCE OF SE
IN COMPLIAN	CE WITH PERSO	NNEL RUI	ES AND RE	SULATIONS, O					NT BECAU	SE OF		
	JRY, OR QUARAN											
	VEEKEND, DAY O ERTIFICATION AS											
	ON FOR SUCH OT											
	IICH WOULD HAV Y. SIÇK LEAVE P											
	AUSE FOR DISM						<del></del>				<del></del> .	
1	AT THE ABOVE N M A MEDICAL ST											
FROM HIS OF	HER TO REPOR	T TO WO	RK.									
FROM (MO	NTH, DAY, YE	AR):	TO (MON	TH, DAY, YE	EAR): ]	HOSPITA	LIZED?		NUMBER	R OF DAYS:		
					1	L_ Y	es	NO .				
NAME OF I	PHYSICIAN (P	RINT OF	R TYPE)			<u> </u>	SIGNATU	JRE OF PHYS	SICIAN			,
REMARKS:												
APPROVED YES NO (SIGNATURE OF EMPLOYEE) AND CORRECT (SIGNATURE OF EMPLOYEE) (SIGNATURE OF EMPLOYEE) (SIGNATURE OF EMPLOYEE)				-1								
APPROVED YES NO (SIGNATURE OF SUPERVISOR) Archite Circu				~								
APPROVED YES NO (SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)												
	Mes Ino											
						s ruck	- 10 m	Juo	~			



# PERSONNE PROPERTY OFFICE

JUL 232015

TIME: 950 1/AM; 1 jrm
TECHNOM: 10

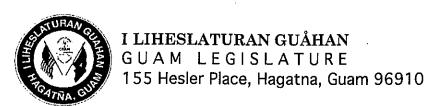
			(	J .		
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:				
VENIDO S. TORRES	,	July 23, 2015	<b>3</b>			
TYPE OF LEAVE REQUESTED:		1	`			
SICK XX ANNUAL MAT	EDUCATION	IAL MILITAR	y JURY	OTHER		
PAY STATUS:	HOURS:	~ 18 7/s	23/15	-		
X W/PAY W/O PAY COMBI	NATION W/PAY					
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR):		Charge Account No	O: 530		
8:00AM 7/20/15	5:00PM 7/20/15					
				· · · · · · · · · · · · · · · · · · ·		
ADDRESS WHILE ON LEAVE: YIGO GU	JAM					
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) CO		AYENT OF VACATION LEAVE				
THE EXPIRATION OF MY PREPAID VACATION, I SHALL RE PORTION OF THE PREPAID LEAVE.	•					
		CERTIFICATION				
N COMPLIANCE WITH PERSONNEL RULES AND REGULA	ATIONS, GOVERNMENT OF GUAM, IF ANY I	EMPLOYEE IS ABSENT BECAUSE				
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THRE A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE G						
FURNISH A CERTIFICATION AS TO THE INCAPACITY FRO CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS						
ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUC						
<b>WITHOUT PAY.</b> SICK LEAVE PORTION FOR TRIVIAL INDIS SUFFICIENT CAUSE FOR <b>DISMISSAL</b> FROM THE GOVERI		IESS REPORT SHALL BE CONSID	DERED			
CERTIFY THAT THE ABOVE NAMED PERSON WAS UND BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER C	ER MY PROFESSIONAL CARE OR QUARA					
FROM HIS OR HER TO REPORT TO WORK. FROM (MONTH, DAY, YEAR): TO (MONT)	H, DAY, YEAR): HOSPITAL	IZED?	IUMBER OF DAYS:			
		ES NO				
NAME OF PHYSICIAN (PRINT OR TYPE)	·	SIGNATURE OF PHYSICIA	AN			
REMARKS:						
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)						
			1			
APPROVED YES NO		(SIGNATURE OF SUPERVISOR)	1			
	(SIGNATURE OF APPOINTING AUTH	L ORITY OR AUTHORIZED DEL	EGATE)			
YES NO		,				



# GUAM LEGISLATURE PERSONNEL / PAYROLL OFFICE

DEC 1 0 2015

		LEAVE	E FORM	TIME: 1045 RECEIVED BY:	[]AM []PM
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	· · · · · · · · · · · · · · · · · · · ·	DATE REQUESTED:		
VENIDO S. TORRES			December 10,	2015	
TYPE OF LEAVE REQUESTED:	<u> </u>			•	
SICK XX ANNUAL MAT	TERNITY []	EDUCATION	AL MILIT	ARY JURY	OTHER
PAY STATUS:	HOURS:		12/10/12		
X W/PAY W/O PAY COMB	NATION	W/PAY	(8) and Wilde	T PAY	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, I	DAY, YEAR):		Charge Accou	nt NO: 530
8:00AM 11/30/15	5:00PM 11/3	0/15			
ADDRESS WHILE ON LEAVE: 147 CHL	. SAIPAN, YIGO, GI	UAM			
			YENT OF VACATION LEA	<del></del>	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) CO	ONSECUTIVE WORKING DAY	YS. IT IS UNDER	RSTOOD THAT IF I RETURN TO	D DUTY BEFORE	
THE EXPIRATION OF MY PREPAID VACATION, I SHALL RE PORTION OF THE PREPAID LEAVE.	EIMBURSE THE GOVERNME	INT IN AN AMOL	INT EQUIVALENT TO THE UNI	EXPIRED	
			CERTIFICATION		
N COMPLIANCE WITH PERSONNEL RULES AND REGUL- LLNESS, INJURY, OR QUARANTINE IN EXCESS OF THRE A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE G- FURNISH A CERTIFICATION AS TO THE INCAPACITY FRO CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH MITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDIE SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVER CERTIFY THAT THE ABOVE NAMED PERSON WAS UND	E CONSECUTIVE WORKING RANTED SICK LEAVE THE O M A REGULAR LICENSEO PH HE DEEMS ADVISABLE, IF T CH CERTIFICATION SHALL B SPOSITION, OR FALSIFICATI NMENT SERVICE.	B DAYS, OR FOR GOVERNMENT E HYSICIAN, THE THE CERTIFICA' BE INDICATED C ON OF AN ILLNI	R THE DAY IMMEDIATELY BEF EMPLOYEE SHALL BE REQUII DEPARTMENT HEAD MAY RE ITION REQUIRED IS NOT FUR IN THE PAYROLL AS LEAVE O ESS REPORT SHALL BE CON	ORE OR AFTER RED TO QUIRE NISHED, ALL F ABSENCE SIDERED	
BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER C FROM HIS OR HER TO REPORT TO WORK.	ONDITION DURING THIS PE	RIOD WAS SUC	H THAT I CONSIDERED IT IN	ADVISABLE	
FROM (MONTH, DAY, YEAR): TO (MONT	H, DAY, YEAR):	HOSPITALI	ZED? ES NO	NUMBER OF DAYS:	
NAME OF PHYSICIAN (PRINT OR TYPE)		<u></u>	SIGNATURE OF PHYSI	CIAN	**************************************
REMARKS:					
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE A	AND CORRECT		(SIGNATURE OF EMPLOYEE	Sim	
APPROVED YES NO			(SIGNATURE OF SUPERVISO	<i>/ C</i> .	Gel
APPROVED YES NO	•	NTING AUTHO	OR AUTHORIZED D	ELEGATE)	



# GUAM LEGISLATURE PERSONNEL I PAYROLL OFFICE

DEC 2 3 2015

			TIME: 1141	MAM []PM
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:	ECEIVED BY:	MUM
Peter H. Tran		December 21, 2015	<b>(2)</b>	
TYPE OF LEAVE REQUESTED:	<u> </u>			
SICK X ANNUAL MAT	TERNITY EDUCATION AND AND AND AND AND AND AND AND AND AN	ONAL MILITARY	JURY	OTHER
PAY STATUS:	HOURS:		<b>A</b>	
X W/PAY W/O PAY COMB	INATION 50 hours	W/OUT PAY_	hours	
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR	₹):	·	
8am December 21, 2015	5pm December 21, 2015	<u> </u>		
	<u> </u>			
ADDRESS WHILE ON LEAVE: Off-islan	d <b>d</b>			
	<del></del>		<u> </u>	
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (10) CO		EPAYENT OF VACATION LEAVE DERSTOOD THAT IF I RETURN TO DUTY F	PEFORE	
THE EXPIRATION OF MY PREPAID VACATION, I SHALL RE				
in the state of th				
IN COMPLIANCE WITH PERSONNEL RULES AND REGULA	ATIONS, GOVERNMENT OF GUAM, IF AN			
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THRE A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE G			AFTER	
FURNISH A CERTIFICATION AS TO THE INCAPACITY FRO CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS	M A REGULAR LICENSED PHYSICIAN, TH	HE DEPARTMENT HEAD MAY REQUIRE	***	
ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUC	CH CERTIFICATION SHALL BE INDICATED	D ON THE PAYROLL AS LEAVE OF ABSEN	ICE	ļ
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDIS SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVER:		LNESS REPORT SHALL BE CONSIDERED	)	
CERTIFY THAT THE ABOVE NAMED PERSON WAS UND BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER C	ER MY PROFESSIONAL CARE OR QUAR			W
FROM HIS OR HER TO REPORT TO WORK.				
FROM (MONTH, DAY, YEAR): TO (MONT	'H, DAY, YEAR): HOSPITA		BER OF DAYS:	
		YES NO		İ
NAME OF PHYSICIAN (PRINT OR TYPE)	· · · · · · · · · · · · · · · · · · ·	SIGNATURE OF PHYSICIAN		
REMARKS:	· · · · · · · · · · · · · · · · · · ·			<del></del>
TALIED IN SO.				•
CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE A	AND CORRECT	(SIGNATURE OF EMPLOYEE)	<u> </u>	
APPROVED YES NO		(SIGNATURE OF SUPERVISOR)	e c. C	20
APPROVED YES NO	(SIGNATURE OF APPOINTING AUT	HORITY OR AUTHORIZED DELEGAT	E)	
<b>/</b>		201	$\mathcal{L}$	)
·			$\sim$	



MAY 1 4 2015

NAME (FIRST MIDDLE LAST).	IDAYDOLL NO.	IDATE DEQUESTED			
NAME (FIRST, MIDDLE, LAST):	PAYROLL NO.:	DATE REQUESTED:			
Thomas J. Unslog	97086	May 5, 20	15. 💖		
TYPE OF LEAVE REQUESTED:					
SICK X ANNUAL M	ATERNITY EDU	JCATIONAL MILIT	ARY JURY OTHER		
PAY STATUS:	HOURS:				
W/PAY W/O PAY COM	BINATION W/F	PAY <u>64</u> W/OL	JT PAY		
FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DA'	Y, YEAR):	Charge Account NO:		
8:00 am May 6, 2015	11:00 am May 15, 2	2015	Charge Account No.		
	11100 ann may 10,				
ADDRESS WHILE ON LEAVE:					
Virgina	. •				
		PREPAYENT OF VACATION L	EAVE		
MINIMUM REQUIREMENT IS NOT LESS THAN TEN (*) THE EXPIRATION OF MY PREPAID VACATION, I SHA					
PORTION OF THE PREPAID LEAVE.		WENT IN AN AMOUNT ECONALEIN	TO THE UNEAPINED		
	Olov I				
IN COMPLIANCE WITH PERSONNEL RULES AND RE		LEAVE CERTIFICATION FIGUAM, IF ANY EMPLOYEE IS ARS	ENT RECAUSE OF		
ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF	THREE CONSECUTIVE WORKIN	NG DAYS, OR FOR THE DAY IMMED	NATELY BEFORE OR AFTER		
A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO					
FURNISH A CERTIFICATION AS TO THE INCAPACITY CERTIFICATION FOR SUCH OTHER PERIOD OF ILLN					
ABSENCE WHICH WOULD HAVE BEEN COVERED B	Y SUCH CERTIFICATION SHALL	BE INDICATED ON THE PAYROLL	AS LEAVE OF ABSENCE		
WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL SUFFICIENT CAUSE FOR DISMISSAL FROM THE GO	and the second s	ATION OF AN ILLNESS REPORT SH	ALL BE CONSIDERED		
I CERTIFY THAT THE ABOVE NAMED PERSON WAS		ARE OR QUARANTINED DURING T	HE PERIOD STATED		
BELOW, FROM A MEDICAL STANDPOINT, HIS OR H	ER CONDITION DURING THIS P	PERIOD WAS SUCH THAT I CONSID	ERED IT INADVISABLE		
FROM HIS OR HER TO REPORT TO WORK. FROM (MONTH, DAY, YEAR): TO (MON'	TH, DAY, YEAR): IHO	SPITALIZED?	NUMBER OF DAYS:		
			, , , , , , , , , , , , , , , , , , ,		
		YES NO			
NAME OF PHYSICIAN (PRINT OR TYPE)	· · · · · · · · · · · · · · · · · · ·	SIGNATURE OF PHY	SICIAN		
REMARKS:					
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT (SIGNATURE OF EMPLOYEE)					
APPROVED					
YES NO		(SIGNATURE OF SUPERV	(SIGNATURE OF SUPERVISOR)		
APPROVED TO THE	(SIGNATURE OF APPOINT	NG AUTHORITY OR AUTHORIZ	ED DELEGATE)		
YES NO	4. (ا	[			
	V	_1			