



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

GUAM LEGISLATURE  
 PERSONNEL/PAYROLL OFFICE

APR 01 2015  
 TIME: 4:15 PM  
 RECEIVED BY: *[Signature]*

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>Scott T. Mendiola</b>		PAYROLL NO.: <b>97547</b>	DATE REQUESTED: <b>March 31, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNIT <input type="checkbox"/> EDUCATIONA <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>24 W</b> W/OUT PAY <b>4-2-15</b> <i>[Handwritten: 24 W, 4-2-15, W/PAY, W/OUT PAY]</i>	
FROM (HOUR, MONTH, DAY, YEAR): <b>April 01, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <del>April 01, 2015</del> <b>April 03, 2015 W</b>	Charge Account NO:	
ADDRESS WHILE ON LEAVE: <b>Chalan Pago</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature: Scott T. Mendiola]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <i>[Signature: Adams]</i>	
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)	



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

GUAM LEGISLATURE  
 PERSONNEL/PAYROLL DIV.

MAY 12 2015  
 MAY 12 2015  
 RECEIVED BY: [Signature]

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <i>VINCENT C. PAULINO</i>		PAYROLL NO.:	DATE REQUESTED: <i>MAY 11, 12 &amp; 13, 2015</i>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <i>20</i> W/OUT PAY <i>20</i> <i>5/11/15</i> <i>OCED</i>	
FROM (HOUR, MONTH, DAY, YEAR): <i>1:00pm May 11, 2015</i>	TO (HOUR, MONTH, DAY, YEAR): <i>5pm May 11, 2015</i>	Charge Account NO:	
<i>8:00am May 12, 2015</i>	<i>5pm May 12, 2015</i>	<i>4 hrs</i>	
<i>8:00am May 13, 2015</i>	<i>5pm May 13, 2015</i>	<i>8 hrs</i>	
ADDRESS WHILE ON LEAVE: <i>143 AB WONDAT DR. AGANA HEIGHTS</i>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>	
APPROVED	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>	



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

**GUAM LEGISLATURE**  
**PERSONNEL/PAYROLL OFFICE**

**MAY 12 2015**  
 TIME: 9:20 AM  
 RECEIVED BY: SO

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <i>Vincent C. Paulino</i>		PAYROLL NO.:	DATE REQUESTED: <i>MAY 11, 2015</i>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <i>25.14-15</i> W/OUT PAY <i>20</i>	
FROM (HOUR, MONTH, DAY, YEAR): <i>8am May 06, 2015</i>	TO (HOUR, MONTH, DAY, YEAR): <i>5pm May 06, 2015</i>	<i>8 hrs.</i>	Charge Account NO:
<i>1pm May 07, 2015</i>	<i>5pm May 07, 2015</i>	<i>4 hrs.</i>	
<i>8am May 14, 2015</i>	<i>5pm May 14, 2015</i>	<i>8 hrs</i>	
ADDRESS WHILE ON LEAVE: <i>143 AB Wompat Dr. Agaña Heights</i>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF AN ILLNESS REPORT SHALL BE CONSIDERED SUFFICIENT CAUSE FOR DISMISSAL FROM THE GOVERNMENT SERVICE.			
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FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

NOV 25 2015

Time: 1005  
 RECEIVED BY: [Signature]

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>JERMAINE ALBERTA</b>		PAYROLL NO.:	DATE REQUESTED: <b>11/23/15</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: <input checked="" type="checkbox"/> W/PAY <b>① 11/23</b> <input type="checkbox"/> W/O PAY	
FROM (HOUR, MONTH, DAY, YEAR): <b>11:00 am 11/23/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>12:00 pm 11/24/15</b>	Charge Account NO:	
ADDRESS WHILE ON LEAVE: <b>Hagatna GU</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <b>[Signature]</b>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <b>[Signature]</b>	
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)	

SEP 30 2015

320  
RECEIVED BY: WCO



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
155 Hesler Place, Hagatna, Guam 96910

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Tina Rose Alicto</b>		PAYROLL NO.: <i>oatme</i>	DATE REQUESTED: <i>ASR</i> <b>September 24, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>24</b> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>9/28/15; 8am</b>	TO (HOUR, MONTH, DAY, YEAR): <b>9/30/15; 5:00pm</b>	Charge Account NO: <b>539</b>	Return on Thursday 10/1/15
ADDRESS WHILE ON LEAVE: <b>Yigo and Mangilao Guam</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Tina Alicto</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR)		
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)		



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Tina Rose Alico</b>		PAYROLL NO.: <b>097716</b>	DATE REQUESTED: <b>November 5, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>11/05/15</b> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>Nov 5, 15; 2:00pm</b> <b>Nov 6, 15; 8:00am</b>		TO (HOUR, MONTH, DAY, YEAR): <b>Nov 5, 15; 5:00pm</b> <b>Nov 6, 15; 5:00pm</b>	
Charge Account NO:			
ADDRESS WHILE ON LEAVE: <b>Mangilao Guam</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <b>Tina Rose Alico</b>	
APPROVED	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <b>[Signature]</b>	
APPROVED	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <b>[Signature]</b>	



ILIHESLATURAN GUAHAN  
 GUAM LEGISLATURE  
 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PERSONNEL & PAYROLL OFFICE

JAN 23 2015

RECEIVED BY: pc

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>Patrick S. Alvarez</b>	PAYROLL NO.: <b>97529</b>	DATE REQUESTED: <b>1-20-15</b>
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TYPE OF LEAVE REQUESTED:

SICK     ANNUAL     MATERNITY     EDUCATIONAL     MILITARY     JURY     OTHER

PAY STATUS:    HOURS:

W/PAY     W/O PAY     COMBINATION

W/PAY **32 hrs.**    W/O PAY \_\_\_\_\_

8am-5pm 1-20-15 - annual  
 8am-5pm 1-21-15 } sick  
 1-23-15 }

FROM (HOUR, MONTH, DAY, YEAR): <b>8am 1-20-15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5pm 1-23-15</b>	CHARGE ACCOUNT NO.:
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ADDRESS WHILE ON LEAVE:  
**Chalan Tun Ben Anaco St. Yigo 96929**

APPLICATION FOR PREPAYMENT OF VACATION 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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.

SICK LEAVE CERTIFICATION  
 IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.

FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
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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 SUPERVISOR)

APPROVED  YES     NO

(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)

**Shane J. King**



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

**GUAM LEGISLATURE**  
**PERSONNEL / PAYROLL OFFICE**

AUG 19 2015  
 TIME: 9:00 AM; 1:1 PM  
 RECEIVED BY: oae

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <u>Ellen G.C. Amas</u>		PAYROLL NO.: <u>897865</u>	DATE REQUESTED: <u>Aug 18, 2015</u>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY: <u>20</u> W/OUT PAY: <u>0</u>	
FROM (HOUR, MONTH, DAY, YEAR): <u>1pm Aug 19, 2015</u>		TO (HOUR, MONTH, DAY, YEAR): <u>5pm Aug 21, 2015</u>	
ADDRESS WHILE ON LEAVE: <u>48 Defoe Crescent, Brampton, Ontario, Canada L6Y 2L2</u>		Charge Account NO:	
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	TO (MONTH, DAY, YEAR): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <u>Ellen G.C. Amas</u>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <u>[Signature]</u>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <u>[Signature]</u>		





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

PE. ...  
 MAY 14 2015  
 8:00  
 RECEIVED BY: *PO*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <i>VIRGILIO F. ARPILLODA</i>		PAYROLL NO.: <i>97749</i>	DATE REQUESTED: <i>5/6/15</i>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input checked="" type="checkbox"/> OTHER <sup>CTO</sup>			
PAY STATUS: <input type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: <input checked="" type="checkbox"/> W/PAY <i>40</i> <i>5-14-15</i> <input type="checkbox"/> W/O PAY <i>36HR</i> <i>OUT PAY</i>	
FROM (HOUR, MONTH, DAY, YEAR): <i>8am 5-11-15</i>		TO (HOUR, MONTH, DAY, YEAR): <i>5pm May 15, 2015</i>	
		Charge Account NO:	
ADDRESS WHILE ON LEAVE: <i># 12 SARIMANOK ST. LACOLINA VILLAGE METRO MANILA</i>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Virgilio F. Arpilloda</i>	
APPROVED	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR)	
APPROVED	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)	
		<i>[Signature]</i>	



**LIHESLATURAN GUÅHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PERSONNEL/PAYROLL OFF

JUNE 11 2015

FILE 1140  
 RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Vincent P. Arriola</b>		PAYROLL NO.: <b>97433</b>	DATE REQUESTED: <b>June 8, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>32</u> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00 am May 26, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5:00 pm May 29, 2015</b>	Charge Account NO:	
ADDRESS WHILE ON LEAVE: <b>Manila, Philippines</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR): [ ] [ ] [ ]	TO (MONTH, DAY, YEAR): [ ] [ ] [ ]	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Vincent P. Arriola</b>		PAYROLL NO.: <b>97433</b>	DATE REQUESTED: <b>September 4, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>40</b> W/OUT PAY <b>17</b>	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00 am September 8, 2015</b>		TO (HOUR, MONTH, DAY, YEAR): <b>5:00 pm September 14, 2015</b>	
ADDRESS WHILE ON LEAVE: <b>Manila</b>			Charge Account NO:
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE)	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR)		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)		



I LIHESLATURAN GUAHAN  
 GUAM LEGISLATURE  
 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PERSONNEL MANAGEMENT OFFICE

JUL 23 2015

TIME: 9:50 AM  
 RECEIVED BY: *[Signature]*

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>JOSEPH MARTINEZ BORJA</b>		PAYROLL NO.:	DATE REQUESTED: <b>July 22, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>8</u> <i>8e</i> <b>7/23/15</b> W/O PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00AM 7/22/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5:00PM 7/22/15</b>	Charge Account NO: 530	
ADDRESS WHILE ON LEAVE: <b>HAGATNA, GUAM</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Joseph Martinez Borja</i>	
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR)		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		





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

GUAM LEGISLATURE  
 PERSONNEL DIVISION

JUN 26 2015  
 300  
 RECEIVED BY: *[Signature]*

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>DANIEL Cabrera</b>		PAYROLL NO.: <b>97764</b>	DATE REQUESTED: <b>June 22, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> INJURY <input checked="" type="checkbox"/> OTHER <b>CTO</b>			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>(32 hrs)</b> W/OUT PAY <b>8 1/2 hrs</b> <b>8 hrs</b> <b>4</b> <b>ANNUAL</b> <b>27</b> <b>CTO</b>	
FROM (HOUR, MONTH, DAY, YEAR): <b>8am 6/23/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>6/26/15</b>	CHARGE ACCOUNT NO.: <b>27 CTO</b>	
ADDRESS WHILE ON LEAVE: <b>127 B AB Wam Pat St. - Sinajana</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



I LHESLATURAN GUAHAN  
GUAM LEGISLATURE  
155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
PERSONNEL/PAYROLL OFFICE

JUL 09 2015  
TIME: 1200 1 1 AM; 1 1 PM  
RECEIVED BY: *[Signature]*

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <i>DANIEL F. CABREDA</i>		PAYROLL NO.: <i>99764</i>	DATE REQUESTED: <i>7-8-15</i>
TYPE OF LEAVE REQUESTED: <input checked="" type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <i>(16) 7-9-15</i> W/OUT PAY <i>8 sick</i>	
FROM (HOUR, MONTH, DAY, YEAR): <i>8 AM Jul 6, 15</i>	TO (HOUR, MONTH, DAY, YEAR): <i>5 PM Jul 7, 15</i>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <i>12713 AB WON PAT ST. SINASANA, SAN</i>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Daniel F. Cabreda</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



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

**GUAM LEGISLATURE**  
**PERSONNEL/PAYROLL OFFICE**

MAY 28 2015

143 x  
 RECEIVED BY: CCP

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Natasha T. Cepeda</b>		PAYROLL NO.:	DATE REQUESTED: <b>MAY 18, 2015</b>
TYPE OF LEAVE REQUESTED: <input checked="" type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <del>40</del> <b>(40)</b> <u>W/ 5/29/15</u> W/OUT PAY <u>16 Annual</u> <u>24 Sick</u>	
FROM (HOUR, MONTH, DAY, YEAR): <b>MAY 18, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <b>MAY 26, 2015</b>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <b>144 DONGO APT. 2 COL. DORIE PEYES LANE CULAPAN DAGO, GUAM 96910</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <u>[Signature]</u>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <u>[Signature]</u>		
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)		





**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

JUL 09 2015  
 RECEIVED BY: cal

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Chauncey L.M. Colbert</b>	PAYROLL NO.: <b>97551</b>	DATE REQUESTED: <b>6/25-26/2015</b>
---	------------------------------	--

TYPE OF LEAVE REQUESTED:

SICK  
  ANNUAL  
  MATERNITY  
  EDUCATIONAL  
  MILITARY  
  JURY  
  OTHER

PAY STATUS:      HOURS:

W/PAY  
  W/O PAY  
  COMBINATION     
 W/PAY 16 <sup>7-8-15</sup>      W/OUT PAY \_\_\_\_\_

*19hrs - Sick  
5hrs - Annual*

FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR):	CHARGE ACCOUNT NO.:
<b>8:00am, 6/25/15</b>	<b>5:00pm, 6/25/15</b>	
<b>8:00am, 6/26/15</b>	<b>5:00pm, 6/26/15</b>	

ADDRESS WHILE ON LEAVE:      **195 Franquez St. Maite, Guam**

**APPLICATION FOR PREPAYMENT OF VACATION 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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.

**SICK LEAVE CERTIFICATION**

IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.

FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED?	NUMBER OF DAYS:
		<input type="checkbox"/> YES <input type="checkbox"/> NO	

NAME OF PHYSICIAN (PRINT OR TYPE)	SIGNATURE OF PHYSICIAN

REMARKS:

I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT	(SIGNATURE OF EMPLOYEE)
	<i>Chauncey Colbert</i>

APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR)
	<i>[Signature]</i>

APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)
	<i>[Signature]</i>



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

**GUAM LEGISLATURE**  
 PERSONNEL MANAGEMENT OFFICE

JUL 23 2015  
 TIME: 1:45 PM  
 RECEIVED BY: 48

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Chauncey L.M. Colbert</b>		PAYROLL NO.: <b>97551</b>	DATE REQUESTED: <b>July 13, 2015</b>
TYPE OF LEAVE REQUESTED: <input checked="" type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>7:10</u> W/O PAY <u>7/23/15 8-A</u> <u>8-S</u>	
FROM (HOUR, MONTH, DAY, YEAR): <b>9:00am, 7/13/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5:00pm, 7/13/15</b>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <b>195 Franquez St. Maite, Guam</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Chauncey Colbert</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		

Leave from  
7/16 & 7/17/15



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
155 Hesler Place, Hagatna, Guam 96910

**GUAM LEGISLATURE**  
**PERSONNEL MANAGEMENT OFFICE**

**LEAVE FORM**

JUL 23 2015  
TIME: 1:45 PM  
RECEIVED BY: *[Signature]*

NAME (FIRST, MIDDLE, LAST): <b>Chauncey L.M. Colbert</b>	PAYROLL NO.: <b>97551</b>	DATE REQUESTED: <b>July 23, 2015</b>
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TYPE OF LEAVE REQUESTED:

SICK  ANNUAL  MATERNITY  EDUCATIONA  MILITARY  JURY  OTHER

PAY STATUS:  W/PAY  W/O PAY  COMBINATION

HOURS: W/PAY 16 8 W/OUT PAY 7 50

FROM (HOUR, MONTH, DAY, YEAR): <b>8:30pm, 7/23/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5:00pm, 7/23/15</b>	CHARGE ACCOUNT NO.:
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ADDRESS WHILE ON LEAVE: **FHP Main Clinic**

**APPLICATION FOR PREPAYMENT OF VACATION 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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.

**SICK LEAVE CERTIFICATION**

IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.

FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
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NAME OF PHYSICIAN (PRINT OR TYPE)	SIGNATURE OF PHYSICIAN
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REMARKS:

I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT	(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>
---	---

APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>
--	---

APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>
--	--



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Chauncey L.M. Colbert</b>	PAYROLL NO.: <b>97551</b>	DATE REQUESTED: <b>7/29-8/3/2015</b>
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TYPE OF LEAVE REQUESTED:

SICK  
  ANNUAL  
  MATERNITY  
  EDUCATIONAL  
  MILITARY  
  JURY  
  OTHER

PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION	HOURS: W/PAY <u>37.63</u> W/OUT PAY <u>9 AM 07-06-15</u>
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FROM (HOUR, MONTH, DAY, YEAR):	TO (HOUR, MONTH, DAY, YEAR):	CHARGE ACCOUNT NO.:
<b>8:00am, 7/29/15</b>	<b>5:00pm, 7/29/15</b>	
<b>8:00am, 8/3/15</b>	<b>5:00pm, 8/3/15</b>	
<b>8am 8/7/15</b>	<b>5pm 8/7/15</b>	

ADDRESS WHILE ON LEAVE:  
**195 Franquez St. Maite, Guam**

**APPLICATION FOR PREPAYMENT OF VACATION 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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.

**SICK LEAVE CERTIFICATION**

IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.

FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED?	NUMBER OF DAYS:
		<input type="checkbox"/> YES <input type="checkbox"/> NO	

NAME OF PHYSICIAN (PRINT OR TYPE)	SIGNATURE OF PHYSICIAN

REMARKS:

I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT	(SIGNATURE OF EMPLOYEE) <i>Chalal</i>
---	--

APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>
--	---

APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>
---	--



I LIHESLATURAN GUAHAN  
 GUAM LEGISLATURE  
 155 Hesler Place, Hagatna, Guam 96910

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>Eliza G. Dames</b>		PAYROLL NO.:	DATE REQUESTED: <b>July 31, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>32 hours</b> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>Friday, July 31, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <b>Wednesday, August 5, 2015</b>	Charge Account NO:	
ADDRESS WHILE ON LEAVE: <b>Vacation - Japan</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Eliza G. Dames</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)		



I LIHESLATURAN GUAHAN  
 GUAM LEGISLATURE  
 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PERSONNEL / PAYROLL OFFICE

DEC 23 2015

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>Blaine A. Dydasco</b>	PAYROLL NO.:	DATE REQUESTED: <b>December 21, 2015</b>	RECEIVED BY: <i>[Signature]</i>
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TYPE OF LEAVE REQUESTED:

SICK   
  ANNUAL   
  MATERNITY   
  EDUCATIONAL   
  MILITARY   
  JURY   
  OTHER

PAY STATUS:

W/PAY   
  W/O PAY   
  COMBINATION

HOURS: *W/PAY 30 hrs B.O.*    W/OUT PAY \_\_\_\_\_

FROM (HOUR, MONTH, DAY, YEAR): <b>8am December 21, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5pm December 24, 2015</b>	Charge Account NO: 530
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ADDRESS WHILE ON LEAVE:  
**Santa Rita, Guam 96915**

APPLICATION FOR PREPAYMENT OF VACATION 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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.

SICK LEAVE CERTIFICATION

IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.

FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
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NAME OF PHYSICIAN (PRINT OR TYPE)	SIGNATURE OF PHYSICIAN
-----------------------------------	------------------------

REMARKS:

I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT

(SIGNATURE OF EMPLOYEE)  
*[Signature]*

APPROVED  YES     NO

(SIGNATURE OF SUPERVISOR)  
*[Signature]*

APPROVED  YES     NO

(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)  
*[Signature]*



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

**GUAM LEGISLATURE**  
**PERSONNEL / PAYROLL OFFICE**

**DEC 23 2015**

**LEAVE FORM**

TIME: 9:30 DATE: 11 PM  
 RECEIVED BY: *[Signature]*

NAME (FIRST, MIDDLE, LAST): <b>Lourdes Pimentel Eclavea</b>	PAYROLL NO.: <b>97834</b>	DATE REQUESTED: <b>December 14, 2015</b>
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TYPE OF LEAVE REQUESTED:

SICK   
 ANNUAL   
 MATERNITY   
 EDUCATIONAL   
 MILITARY   
 JURY   
 OTHER

PAY STATUS:    HOURS:

W/PAY   
 W/O PAY   
 COMBINATION   
 W/PAY   
 W/O PAY

Other: "Bereavement" (Consanguinity)

FROM (HOUR, MONTH, DAY, YEAR): <b>0800, December 14, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <b>1700, December 15, 2015</b>	Charge Account NO: <b>501</b>
<b>0800, December 16, 2015</b>	<b>1700, December 18, 2015</b>	<b>501</b>

ADDRESS WHILE ON LEAVE:  
**Agana Heights, Guam**

**APPLICATION FOR PREPAYMENT OF VACATION 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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.

**SICK LEAVE CERTIFICATION**

IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.

FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
--------------------------	------------------------	---	-----------------

NAME OF PHYSICIAN (PRINT OR TYPE)	SIGNATURE OF PHYSICIAN
-----------------------------------	------------------------

REMARKS:

I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT	(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>
---	---

APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>
--	---

APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>
--	--



I LIHESLATURAN GUAHAN  
 GUAM LEGISLATURE  
 155 Hesler Place, Hagatna, Guam 96910

NOV 25 2015

REC'D  
 REGISTERED

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <i>Julian, C, Janssen</i>		PAYROLL NO.:	DATE REQUESTED: <i>11/23/2015</i>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u><i>11/23/2015</i></u> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <i>11:00am 11/23/2015</i>		TO (HOUR, MONTH, DAY, YEAR): <i>12pm 11/23/2015</i>	
ADDRESS WHILE ON LEAVE: <i>Hagatna Gu</i>		Charge Account NO:	
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>	
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)	



Original filed w/ PPE 9-5-15



I LIHESLATURAN GUAHAN  
GUAM LEGISLATURE  
155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
PERSONNEL / PAYROLL OFFICE

SEP 17 2015

TIME: 3:00 PM  
RECEIVED BY: [Signature]

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <i>Josefina Javelosa</i>		PAYROLL NO.: <i>97818</i>	DATE REQUESTED: <i>7/7/15</i>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input checked="" type="checkbox"/> OTHER <i>CTO</i>			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <i>152</i> <i>10:01-15</i> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <i>Aug 31, 2015</i> <i>8:00 AM</i>		TO (HOUR, MONTH, DAY, YEAR): <i>Sept 25, 2015</i> <i>5:00 PM</i>	
ADDRESS WHILE ON LEAVE: <i>AZ, CALI Mainland</i>		Charge Account NO: <i>Ann. 34 hrs</i> <i>Comp. 6</i> <i>Ø COMP</i> <i>72 Ann. ppe 9-19-15</i> <i>40 Ann. ppe 10-03-15</i>	
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE. <span style="float: right;"><i>Ø ANN HRS</i></span>			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hessler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PERSONNEL/ HUMAN RESOURCES OFFICE

OCT 01 2015  
 TIME: 11:51 AM  
 RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Velma M. Komiyama</b>		PAYROLL NO.: <b>97426</b>	DATE REQUESTED: <b>9/23/15</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
<input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>17:00-18:15</b> W/O PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>5 PM 9/30/15</b>		TO (HOUR, MONTH, DAY, YEAR): <b>5 PM 10/2/15</b>	
CHARGE ACCOUNT NO.:			
ADDRESS WHILE ON LEAVE: <b>Las Vegas, NV</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>	



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hessler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PERSONNEL / HUMAN RESOURCES

OCT 15 2015  
 TIME: 12:35  
 RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Velma M. Komiyama</b>		PAYROLL NO.: <b>97426</b>	DATE REQUESTED: <b>9/23/15</b>
TYPE OF LEAVE REQUESTED: <input checked="" type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
<input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>(72)</b> <i>10/15/15</i> W/O OUT PAY _____	Ann. 32 Hrs Sick 48 Hrs
FROM (HOUR, MONTH, DAY, YEAR): <b>8 AM 10/5/15</b>		TO (HOUR, MONTH, DAY, YEAR): <b>5 PM 10/15/15</b>	
ADDRESS WHILE ON LEAVE: <b>Las Vegas, NV</b>		CHARGE ACCOUNT NO.:	
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>	





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

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <i>Kenneth W. Lambunaw</i>	PAYROLL NO.: <i>97431</i>	DATE REQUESTED: <i>07/26/15</i>
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TYPE OF LEAVE REQUESTED:

SICK  
  ANNUAL  
  MATERNITY  
  EDUCATIONAL  
  MILITARY  
  JURY  
  OTHER *Bereavement*

PAY STATUS:      HOURS:

W/PAY  
  W/O PAY  
  COMBINATION     
 *32 24*     
 *07-06-15*

*8:00 07/27/15*     
 W/PAY     
 W/O PAY     
*07-06-15*

FROM (HOUR, MONTH, DAY, YEAR): <i>8:00 07/30/15</i>	TO (HOUR, MONTH, DAY, YEAR): <i>5:00 07/30/15</i>	Charge Account NO:
<i>8:00 08/03/15</i>	<i>5:00 08/03/15</i>	
<i>8:00 08/04/15</i>	<i>5:00 08/04/15</i>	

ADDRESS WHILE ON LEAVE:  
*54th Main Road Chalan Pingo Guam / 310 Ysengsong Dededo Guam*

**APPLICATION FOR PREPAYMENT OF VACATION 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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.

**SICK LEAVE CERTIFICATION**

IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.

FROM (MONTH, DAY, YEAR): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	TO (MONTH, DAY, YEAR): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
--	--	---	-----------------

NAME OF PHYSICIAN (PRINT OR TYPE)	SIGNATURE OF PHYSICIAN
-----------------------------------	------------------------

REMARKS:

I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT	(SIGNATURE OF EMPLOYEE) <i>Curr</i>
---	--

APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>
--	---

APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>
--	--



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

**GUAM LEGISLATURE**  
**PERSONNEL PAYMENT OFFICE**

APR 29 2015

3:30 PM

RECEIVED BY: [Signature]

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>JOHN DEK ANTONIO LUCES</b>		PAYROLL NO.: <b>97783</b>	DATE REQUESTED: <b>4-28-15 to 5-1-15</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input checked="" type="checkbox"/> OTHER <i>oae</i>			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>(32)</b> W/OUT PAY <b>18 4/30/15</b>	
FROM (HOUR, MONTH, DAY, YEAR): <b>8AM-<del>11AM</del> 4-28-15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5PM 5-1-15</b>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <b>SACRAMENTO, CALIFORNIA</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>	
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>	



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
155 Hesler Place, Hagatna, Guam 96910

GOVERNMENT OF GUAM  
1555 HESLER PLACE, HAGATNA, GUAM 96910

NOV 25 2015

1005

RELAYED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>JOHN PAUL MANUEL</b>		PAYROLL NO.:	DATE REQUESTED: <b>11/23/15</b>	
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER				
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>(2) 9AM-11/25</b> W/OUT PAY		
FROM (HOUR, MONTH, DAY, YEAR): <b>11AM 11/23/15</b> <b>1PM 11/23/15</b>		TO (HOUR, MONTH, DAY, YEAR): <b>12 PM 11/23/15</b> <b>2 PM 11/23/15</b>		Charge Account NO:
ADDRESS WHILE ON LEAVE: <b>Hagatna GU</b>				
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>				
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.				
<b>SICK LEAVE CERTIFICATION</b>				
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.				
FROM (MONTH, DAY, YEAR):		TO (MONTH, DAY, YEAR):		HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO
				NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)			SIGNATURE OF PHYSICIAN	
REMARKS:				
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT			(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>	
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO			(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)	



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hessler Place, Hagatna, Guam 96910

RECEIVED BY: OLL  
 JUL 09 2015  
 11:53 AM

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <i>Joseph Anthony Mesnyon</i>		PAYROLL NO.:	DATE REQUESTED: <i>6/26/15</i>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <i>7.8</i> <sup>JM</sup> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <i>8am July 02, 2015</i>	TO (HOUR, MONTH, DAY, YEAR): <i>3pm July 16, 2015</i>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <i>386 Chap. Pale Ramon Yigo</i>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE)	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR)	
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)	





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

**GUAM LEGISLATURE**  
**PERSONNEL OFFICE**

JUL 23 2015

TIME: 12:10 PM  
 RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <i>Joseph Anthony Mesnyon</i>		PAYROLL NO.:	DATE REQUESTED: <i>6/26/15</i>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <i>7.8</i> <sup>JM</sup> W/OUT PAY _____ <i>(36) PPE 7-25-15 JR</i>	
FROM (HOUR, MONTH, DAY, YEAR): <i>8am July 02, 2015</i>	TO (HOUR, MONTH, DAY, YEAR): <i>3pm July 16, 2015</i>	CHARGE ACCOUNT NO.: <i>original filed w/ PPE 7-11-15</i>	
ADDRESS WHILE ON LEAVE: <i>386 Cien. Pale Ramon Yigo</i>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)	SIGNATURE OF PHYSICIAN		
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)		



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

NOV 25 2015

1105  
 RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>T'NEETA S. MORI</b>		PAYROLL NO.:	DATE REQUESTED: <b>11/23/15</b>	
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER				
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>(2) 11/23</b> W/OUT PAY _____		
FROM (HOUR, MONTH, DAY, YEAR): <b>1100 11-23-15</b>		TO (HOUR, MONTH, DAY, YEAR): <b>1200 11-23-15</b>		Charge Account NO:
<b>1300 11-23-15</b>		<b>1400 11-23-15</b>		
ADDRESS WHILE ON LEAVE: <b>Hagatna GU</b>				
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>				
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.				
<b>SICK LEAVE CERTIFICATION</b>				
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.				
FROM (MONTH, DAY, YEAR):		TO (MONTH, DAY, YEAR):		HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO
				NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)			SIGNATURE OF PHYSICIAN	
REMARKS:				
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT			(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>	
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO			(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)	



I LIHESLATURAN GUAHAN  
 GUAM LEGISLATURE  
 155 Hessler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PERSONNEL/PAYROLL OFFICE

FEB 05 2015

TIME: 1:25 PM JAN 14 PM

RECEIVED BY: *[Signature]*

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>DANIEL D. PEREZ</b>		PAYROLL NO.: <b>642240</b>	DATE REQUESTED: <b>1/30/15</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>(8)</b> <b>2/6/15</b> <i>[Signature]</i> W/O OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00 a.m. 2/2/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5:00 p.m. 2/2/15</b>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <b>421 TAPIGIAO, AGANA HTS.</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <b>RENNAL VANESSA MENO</b>	
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)	



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hessler Place, Hagatna, Guam 96910

RECEIVED BY: SR  
 JUN 11 2015  
 1:55

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>DANIEL D. PEREZ</b>		PAYROLL NO.: <b>642248</b>	DATE REQUESTED: <b>6/11/15</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>(4)</b> <b>8:00/12/15</b> W/O PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00 A.M. 6/11/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>12:00 P.M. 6/11/15</b>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <b>421 TAIGIGAO, AGANA HTS.</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Daniel D. Perez</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <b>RENNAE VANESSA MENO</b>		
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)		



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

GUAM LEGISLATURE  
 PERSONNEL/PAYROLL OFFICE

JUN 25 2015

RECEIVED BY: *[Signature]*

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>DANIEL D. PEREZ</b>		PAYROLL NO.: <b>642240</b>	DATE REQUESTED: <b>6/23/15</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>8</b> W/OUT PAY <b>18 6/25/14</b>	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00 A.M. 6/24/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5:00 P.M. 6/24/15</b>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <b>421 TAIGIGAO, AGANA HTS.</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INCAPACITY, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <b>RENNAE VANESSA MENO</b>	
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>	



I LIHESLATURAN GUAHAN  
GUAM LEGISLATURE  
155 Hessler Place, Hagatna, Guam 96910

JUL 09 2015  
RECEIVED BY: ESS 11:45 AM  
COE

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): DANIEL D. PEREZ		PAYROLL NO.: 642240	DATE REQUESTED: 6/30/15
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>8</u> <u>7.9-15</u> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): 1:00 P.M. 6/30/15 /	TO (HOUR, MONTH, DAY, YEAR): 12:00 P.M. 7/1/15 /	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: 421 TAIGIGAO, AGANA HTS.			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Daniel D. Perez</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <b>RENNAE VANESSA MENO</b>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)		



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hessler Place, Hagatna, Guam 96910

**GUAM LEGISLATURE**  
**PERSONNEL OFFICE**

JUL 23 2015

JUL 21 1 14 PM

RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>DANIEL P. PEREZ</b>		PAYROLL NO.: <b>642240</b>	DATE REQUESTED: <b>7/15/15</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <b>(12)</b> <b>7/22/15</b> W/O PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00 a.m. 7/15/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>12:00 p.m. 7/16/15</b>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <b>421 TAIGIGAO, AGANA HTS.</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <b>RENNAE VANESSA MENO</b>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>	



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hessler Place, Hagatna, Guam 96910

DO NOT WRITE IN THESE SPACES

OCT 15 2015

DATE: 10/5/15  
 RECEIVED BY: [Signature]

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>DANIEL D. PEREZ</b>		PAYROLL NO.: <b>642240</b>	DATE REQUESTED: <b>10/5/15</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>1</u> W/O PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8 a.m. 10/5/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>9 a.m. 10/5/15</b>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <b>421 TAIGIGA, AGANA HTS.</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPURED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INCONSPICUOUS, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <b>[Signature]</b>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <b>RENNAE VANESSA MENO</b>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <b>[Signature]</b>	





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

GUAM LEGISLATURE  
PERSONNEL/PAYROLL OFFICE

MAY 04 2015

TIME: 1:00  
RECEIVED BY: *[Signature]*

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>Wilfred T. Pinzon</b>		PAYROLL NO.: <b>97762</b>	DATE REQUESTED: <b>April 27, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER <b>workman's comp</b>			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>8hrs</u> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00am April 27, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5:00pm April 27, 2015</b>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <b>92 San Miguel St. Taloffo, Guam</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR): [ ] [ ] [ ]	TO (MONTH, DAY, YEAR): [ ] [ ] [ ]	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Wilfred T. Pinzon</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



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

GUAM LEGISLATURE  
 PERSONNEL/PAYROLL OFFICE

MAY 28 2015

FILE 100 JAN 17 2015  
 RECEIVED BY: *[Signature]*

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>Pinzon, Wilfred</b>		PAYROLL NO.: <b>97762</b>	DATE REQUESTED: <b>May 28, 2015</b>
TYPE OF LEAVE REQUESTED:			
<input checked="" type="checkbox"/> SICK	<input checked="" type="checkbox"/> ANNUAL	<input type="checkbox"/> MATERNITY	<input type="checkbox"/> EDUCATIONAL
<input type="checkbox"/> MILITARY	<input type="checkbox"/> JURY	<input type="checkbox"/> OTHER	CTO
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: <b>11 5/29/15</b> W/PAY <b>12hrs.</b> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8am 5/20/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5pm 5/20/15</b>	CHARGE ACCOUNT NO.: <b>8hrs Sick</b>	
<b>12am 5/26/15</b>	<b>4pm 5/26/15</b>	<b>3 Hrs Annual</b>	
ADDRESS WHILE ON LEAVE: <b>92 San Miguel St., Talofofo Guam</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Wilfred Pinzon</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATEE) <i>[Signature]</i>		



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

GUAM LEGISLATURE  
 PERSONNEL PATROLL OFFICE  
 MAY 28 2015  
 FILE: 100  
 RECEIVED BY: *oel*

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>Pinzon, Wilfred</b>		PAYROLL NO.: <b>97762</b>	DATE REQUESTED: <b>May 28, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: (11) 5/29/15 W/PAY <u>12 hrs. OOL</u> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>1pm 5/28/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>4pm 5/28/15</b>	CHARGE ACCOUNT NO.: <b>34 hrs ANNUAL</b>	
<b>8am 5/29/15</b>	<b>5pm 5/29/15</b>	<b>8 hrs ANNUAL</b>	
ADDRESS WHILE ON LEAVE: <b>92 San Miguel St., Talofofu Guam</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR): [ ] [ ] [ ]	TO (MONTH, DAY, YEAR): [ ] [ ] [ ]	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS: [ ]
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Wilfred Pinzon</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>	



**LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

**GUAM LEGISLATURE**  
**PERSONNEL/PAYROLL OFFICE**

JUL 23 2015  
 TIME: 1:23 PM  
 RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Wilfred T. Pinzon</b>		PAYROLL NO.: <b>97762</b>	DATE REQUESTED: <b>July 17, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input checked="" type="checkbox"/> OTHER <span style="float: right;">cto</span>			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>8hrs</u> <i>7/24/15</i> W/OUT PAY <u>4 HRS CTO</u> <u>4 HRS ANNUAL</u>	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00am July 17, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5:00pm July 17, 2015</b>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <b>243 North San Miguel St. Talofof, Guam</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Wilfred T. Pinzon</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



I LHESLATURAN GUAHAN  
 GUAM LEGISLATURE  
 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PERSONNEL MANAGEMENT OFFICE

JUL 23 2015

TIME: 11:23 AM

RECEIVED BY: [Signature]

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <b>Wilfred T. Pinzon</b>		PAYROLL NO.: <b>97762</b>	DATE REQUESTED: <b>July 20, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER <span style="float: right;">cto</span>			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>6hrs</u> <sup>7/24/15</sup> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>10:00am July 20, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <b>4:00pm July 20, 2015</b>	CHARGE ACCOUNT NO.: -	
ADDRESS WHILE ON LEAVE: <b>243 North San Miguel St. Talofof, Guam</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR): [ ] [ ] [ ]	TO (MONTH, DAY, YEAR): [ ] [ ] [ ]	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS: [ ]
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Wilfred T. Pinzon</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PERSONNEL/PAYROLL OFFICE

**LEAVE FORM**

AUG 20 2015  
 DIVISION: HRM: NIPM  
 RECEIVED BY: *[Signature]*

NAME (FIRST, MIDDLE, LAST): <i>WILFRED TANTON</i>		PAYROLL NO.: <i>97702</i>	DATE REQUESTED: <i>8-13-15</i>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <i>(4)</i> <i>8:20-15</i> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <i>7AM 8-13-15</i>	TO (HOUR, MONTH, DAY, YEAR): <i>11AM 8-13-15</i>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <i>92 San Miguel St TACOFORO GUAM 96915</i>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Wilfred Tanton</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>Shamus J. Lopez</i>		



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

**GUAM LEGISLATURE**  
**PERSONNEL/PAYROLL OFFICE**

APR 03 2015  
 TIME: 10:10  
 RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Tricia Ann S. Pocalgue</b>		PAYROLL NO.: <b>97792</b>	DATE REQUESTED: <b>March 31, 2015</b>
TYPE OF LEAVE REQUESTED: <input checked="" type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input checked="" type="checkbox"/> <sup>CTD</sup> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY          16          3 CTO          8 Sick          5 Annual          4-3-15 W/OUT <i>5 cal</i>	
FROM (HOUR, MONTH, DAY, YEAR): <b>8am, Mar.27, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5pm, Mar.30, 2015</b>	Charge Account NO:	
ADDRESS WHILE ON LEAVE: <b>127 RB Qultaro St. Yona, Guam 96915</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Tricia Ann S. Pocalgue</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
155 Hesler Place, Hagatna, Guam 96910

PERMANENT LEGISLATURE  
MAY 28 2015  
TIME: 11:27 AM  
RECEIVED BY: Gal

### LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <u>Tricia Pocaique</u>		PAYROLL NO.: <u>97792</u>	DATE REQUESTED: <u>5/21/15</u>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>3</u> <u>5/29/15</u> W/O UT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <u>2pm May 29, 2015</u>	TO (HOUR, MONTH, DAY, YEAR): <u>5pm May 29, 2015</u>	Charge Account NO:	
ADDRESS WHILE ON LEAVE: <u>428 chalan San Antonio suite 101 Tam, 96913</u>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR): [ ] [ ] [ ]	TO (MONTH, DAY, YEAR): [ ] [ ] [ ]	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <u>Tricia Pocaique</u>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <u>[Signature]</u>		
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <u>[Signature]</u>		





**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <i>Tricia Pocaigue</i>		PAYROLL NO.: <i>97792</i>	DATE REQUESTED: <i>7/13/15</i>
TYPE OF LEAVE REQUESTED: <input checked="" type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <i>(56)</i> <sup>7/13/15</sup> <del>SICK - 24 hrs</del> <del>HOLIDAY - 8 hrs</del> <del>W/O UTRAY</del> Annual - 10 hrs.	
FROM (HOUR, MONTH, DAY, YEAR): <i>8am July 01, 2015</i>	TO (HOUR, MONTH, DAY, YEAR): <i>5pm July 10, 2015</i>	Charge Account NO:	
ADDRESS WHILE ON LEAVE: <i>FHP Health Center / 107 RB Quitaro St. Yona Gu.</i>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR): <input type="checkbox"/>	TO (MONTH, DAY, YEAR): <input type="checkbox"/>	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS: <input type="checkbox"/>
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Tricia A. Pocaigue</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



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

**GUAM LEGISLATURE**  
 PERSONNEL & PAYROLL OFFICE

JUL 23 2015

TIME: 1:45 PM JAN 1 11PM

RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <i>Tricia Pocaique</i>		PAYROLL NO.: <i>97752</i>	DATE REQUESTED: <i>7/23/15</i>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <input checked="" type="checkbox"/> <i>8</i> <i>8</i> <i>7/23/15</i> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <i>8am 7/22/2015</i>	TO (HOUR, MONTH, DAY, YEAR): <i>5pm 7/22/2015</i>	Charge Account NO:	
ADDRESS WHILE ON LEAVE: <i>127 RB Quitaro st. Yona Gu.</i>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Tricia A. Pocaique</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

MAY 01 2015  
 RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Agnes B. Rumbaoa</b>		PAYROLL NO.: <b>97778</b>	DATE REQUESTED: <b>April 20, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>8</u> <i>slits</i> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00 am 04/28/15</b>		TO (HOUR, MONTH, DAY, YEAR): <b>5:00 pm 04/28/15</b>	
Charge Account NO:			
ADDRESS WHILE ON LEAVE: <b>276 Little Manilla Finile Drive Agat, Guam</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):		TO (MONTH, DAY, YEAR):	
<input type="checkbox"/>		<input type="checkbox"/>	
HOSPITALIZED?		NUMBER OF DAYS:	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Agnes B. Rumbaoa</i> Agnes B. Rumbaoa	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR)	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>	



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

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Agnes B. Rumbaoa</b>		PAYROLL NO.: <b>97778</b>	DATE REQUESTED: <b>July 29, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>12 (8) FROM 08-06-15</u> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <u>8:00 am 07-31-15</u> <u>12:00 am 07/30/15</u>		TO (HOUR, MONTH, DAY, YEAR): <b>5:00 pm 07/31/15</b>	Charge Account NO:
ADDRESS WHILE ON LEAVE: <b>276 Little Manila Finile Dr. Agat, Guam 96928</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Agnes B. Rumbaoa</i> Agnes B. Rumbaoa	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>	



ILIHESLATURAN GUAHAN  
GUAM LEGISLATURE  
155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
CONNECTIONS OFFICE

OCT 01 2015

TIME: 9:50 AM  
RECEIVED BY: KR

LEAVE FORM

NAME (FIRST, MIDDLE, LAST): <i>Joseph San Agustin</i>		PAYROLL NO.: <i>97710</i>	DATE REQUESTED: <i>10-1-15</i>
TYPE OF LEAVE REQUESTED:			CTO
<input type="checkbox"/> SICK	<input checked="" type="checkbox"/> ANNUAL	<input type="checkbox"/> MATERNITY	<input type="checkbox"/> EDUCATIONAL
<input type="checkbox"/> MILITARY	<input type="checkbox"/> JURY	<input type="checkbox"/> OTHER	
PAY STATUS:		HOURS:	
<input checked="" type="checkbox"/> W/PAY	<input type="checkbox"/> W/O PAY	<input type="checkbox"/> COMBINATION	W/PAY <i>(4 hrs. 9:00-1:00)</i> W/OUT PAY _____
FROM (HOUR, MONTH, DAY, YEAR): <i>1pm 9-25-15</i>	TO (HOUR, MONTH, DAY, YEAR): <i>5pm 9-25-15</i>	CHARGE ACCOUNT NO.:	
ADDRESS WHILE ON LEAVE: <i>107 Thomas St. Tamuning</i>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>Adam Beaulieu</i>	
APPROVED	<input type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)	



**LIHESLATURAN GUÅHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 HOUSE OF REPRESENTATIVES

JUN 11 2015  
 145 1 AM  
 RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <i>RONALD TEEHAN JR.</i>		PAYROLL NO.:	DATE REQUESTED: <i>JUNE 11, 2015</i>
TYPE OF LEAVE REQUESTED: <input checked="" type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: <input type="checkbox"/> W/PAY <i>16 HRS 10-12-15</i> <input type="checkbox"/> W/OUT PAY	
FROM (HOUR, MONTH, DAY, YEAR): <i>JUNE 10, 2015</i>		TO (HOUR, MONTH, DAY, YEAR): <i>JUNE 11, 2015</i>	
ADDRESS WHILE ON LEAVE: <i>TALAPOFO, GUAM</i>		Charge Account NO:	
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>Ronald Teehan Jr.</i>	
APPROVED	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>	
APPROVED	<input type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)	



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PERSONNEL/PAIDROLL OFFICE

NOV 25 2015

217  
 RECEIVED BY: *[Signature]*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <i>RONALD JOSEPH</i>		PAYROLL NO.:	DATE REQUESTED: <i>NOV. 25, 2015</i>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <i>(64) 11-25-15</i> W/OUT PAY <i>000</i>	
FROM (HOUR, MONTH, DAY, YEAR): <i>8AM NOV. 16, 2015</i>	TO (HOUR, MONTH, DAY, YEAR): <i>5PM NOV. 25, 2015</i>	Charge Account NO:	
ADDRESS WHILE ON LEAVE: <i>[Signature]</i>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>		



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

**GUAM LEGISLATURE**  
**PERSONNEL OFFICE**

JUL 23 2015

TIME: 9:50 AM  
 RECEIVED BY:

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>VENIDO S. TORRES</b>		PAYROLL NO.:	DATE REQUESTED: <b>July 23, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>8</u> <b>7/23/15</b> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00AM 7/20/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5:00PM 7/20/15</b>	Charge Account NO: 530	
ADDRESS WHILE ON LEAVE: <b>YIGO GUAM</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) 	
APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR)	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) 	





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

GUAM LEGISLATURE  
 PERSONNEL / PAYROLL OFFICE

DEC 10 2015

LEAVE FORM

TIME: 1045 ~~6~~ AM [ ] PM  
 RECEIVED BY: JS

NAME (FIRST, MIDDLE, LAST): <b>VENIDO S. TORRES</b>		PAYROLL NO.:	DATE REQUESTED: <b>December 10, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input checked="" type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>(8)</u> <sup>12/10/15</sup> <sub>9:00AM</sub> W/O OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00AM 11/30/15</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5:00PM 11/30/15</b>	Charge Account NO: 530	
ADDRESS WHILE ON LEAVE: <b>147 CHL SAIPAN, YIGO, GUAM</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE)	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR)		
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE)		



I LIHESLATURAN GUAHAN  
 GUAM LEGISLATURE  
 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PERSONNEL / PAYROLL OFFICE

DEC 23 2015

LEAVE FORM

TIME: 1045 AM 11 PM

RECEIVED BY: *[Signature]*

NAME (FIRST, MIDDLE, LAST): <b>Peter H. Tran</b>	PAYROLL NO.:	DATE REQUESTED: <b>December 21, 2015</b>
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TYPE OF LEAVE REQUESTED:

SICK   
  ANNUAL   
  MATERNITY   
  EDUCATIONAL   
  MILITARY   
  JURY   
  OTHER

PAY STATUS:

W/PAY   
  W/O PAY   
  COMBINATION

HOURS: *36 hours W/PAY*

W/OUT PAY *9 hours*

FROM (HOUR, MONTH, DAY, YEAR): <b>8am December 21, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <b>5pm December 21, 2015</b>
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ADDRESS WHILE ON LEAVE:  
**Off-Island**

APPLICATION FOR PREPAYMENT OF VACATION 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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.

SICK LEAVE CERTIFICATION

IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.

FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
--------------------------	------------------------	---	-----------------

NAME OF PHYSICIAN (PRINT OR TYPE)	SIGNATURE OF PHYSICIAN
-----------------------------------	------------------------

REMARKS:

I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT	(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>
---	---

APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>
--	---

APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>
--	--



**I LIHESLATURAN GUAHAN**  
**GUAM LEGISLATURE**  
 155 Hesler Place, Hagatna, Guam 96910

GUAM LEGISLATURE  
 PER. STAFF / PERSONNEL DIV.  
 MAY 14 2015  
 TIME: 8:00 AM  
 RECEIVED BY: *PD*

**LEAVE FORM**

NAME (FIRST, MIDDLE, LAST): <b>Thomas J. Unslog</b>		PAYROLL NO.: <b>97086</b>	DATE REQUESTED: <b>May 5, 2015</b>
TYPE OF LEAVE REQUESTED: <input type="checkbox"/> SICK <input checked="" type="checkbox"/> ANNUAL <input type="checkbox"/> MATERNITY <input type="checkbox"/> EDUCATIONAL <input type="checkbox"/> MILITARY <input type="checkbox"/> JURY <input type="checkbox"/> OTHER			
PAY STATUS: <input type="checkbox"/> W/PAY <input type="checkbox"/> W/O PAY <input type="checkbox"/> COMBINATION		HOURS: W/PAY <u>64</u> W/OUT PAY _____	
FROM (HOUR, MONTH, DAY, YEAR): <b>8:00 am May 6, 2015</b>	TO (HOUR, MONTH, DAY, YEAR): <b>11:00 am May 15, 2015</b>	Charge Account NO:	
ADDRESS WHILE ON LEAVE: <b>Virginia</b>			
<b>APPLICATION FOR PREPAYMENT OF VACATION LEAVE</b>			
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 IN AN AMOUNT EQUIVALENT TO THE UNEXPIRED PORTION OF THE PREPAID LEAVE.			
<b>SICK LEAVE CERTIFICATION</b>			
IN COMPLIANCE WITH PERSONNEL RULES AND REGULATIONS, GOVERNMENT OF GUAM, IF ANY EMPLOYEE IS ABSENT BECAUSE OF ILLNESS, INJURY, OR QUARANTINE IN EXCESS OF THREE CONSECUTIVE WORKING DAYS, OR FOR THE DAY IMMEDIATELY BEFORE OR AFTER A HOLIDAY, WEEKEND, DAY OFF, OR VACATION, TO BE GRANTED SICK LEAVE THE GOVERNMENT EMPLOYEE SHALL BE REQUIRED TO FURNISH A CERTIFICATION AS TO THE INCAPACITY FROM A REGULAR LICENSED PHYSICIAN. THE DEPARTMENT HEAD MAY REQUIRE CERTIFICATION FOR SUCH OTHER PERIOD OF ILLNESS HE DEEMS ADVISABLE. IF THE CERTIFICATION REQUIRED IS NOT FURNISHED, ALL ABSENCE WHICH WOULD HAVE BEEN COVERED BY SUCH CERTIFICATION SHALL BE INDICATED ON THE PAYROLL AS LEAVE OF ABSENCE WITHOUT PAY. SICK LEAVE PORTION FOR TRIVIAL INDISPOSITION, OR FALSIFICATION OF 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 OR QUARANTINED DURING THE PERIOD STATED BELOW. FROM A MEDICAL STANDPOINT, HIS OR HER CONDITION DURING THIS PERIOD WAS SUCH THAT I CONSIDERED IT INADVISABLE FROM HIS OR HER TO REPORT TO WORK.			
FROM (MONTH, DAY, YEAR):	TO (MONTH, DAY, YEAR):	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NUMBER OF DAYS:
NAME OF PHYSICIAN (PRINT OR TYPE)		SIGNATURE OF PHYSICIAN	
REMARKS:			
I CERTIFY ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT		(SIGNATURE OF EMPLOYEE) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF SUPERVISOR) <i>[Signature]</i>	
APPROVED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		(SIGNATURE OF APPOINTING AUTHORITY OR AUTHORIZED DELEGATE) <i>[Signature]</i>	