## GOVERNMENT OF GUAM DEPARTMENT OF EDUCATION

## SICK/ANNUAL LEAVE DONATION REQUEST FOR MEDICAL EMERGENCY REASONS

|                        |   | LEAVE RECIPIENT  |   | LEAVE DONOR  |
|------------------------|---|--|---|--|
| EMP                    |   |  | -   |  |
| soc                    | IAL SECURITY NO.  |  |   |  |
| CLA                    | SS TITLE, PAY GRADE/STEP  |  |   |  |
| AGE                    | NCY/DIVISION  |  |   |  |
|                        | FROM -  |  |   |  |
| DON                    | ATED LEAVE PERIOD: TO:  |  | TOTAL<br>HOURS:                                       |  |
| EXPL                   | ANATION OF ILLNESS/INJURY:  |  |   |  |
| <u></u>                |   |  | · · · · · · · · · · · · · · · · · · ·                 |  |
| leave                  | by certify that I have secured permission from<br>above referenced illness/injury and will be use<br>will be exhausted first before the donated leav<br>ication of Leave:           | ny agency to use donated sick/annual leave pur<br>d during the dates listed above in order to conti<br>e.                  | inue my compensation.                                 | ng procedures. This request is du<br>I understand that my own accure       |
| Certif                 |   |  | Date  |  |
|                        |   | ceipient's Signature   |   |  |
| A.                     | IFICATION FROM LEAVE RECIPIENT'S PA   |  |   |  |
| Α.                     |   | donated leave has accrued the following hours  |   | it.  |
|                        |   | Balance:   | PPE:  |  |
|                        |   | Balance:   | PPE:  |  |
|                        |   | Balance:   | PPE:  |  |
| Payro                  | Il Supervisor:  |  | Date  |  |
| CERT                   | FICATION OF LEAVE DONOR   |  |   |  |
|                        |   | no the leave hours on item 5 above and request   | that my Payroll Supen                                 | increase for the phone listed by   |
| A.                     | I hereby certify that I am voluntarily donati<br>of my sick/annual leave to the Leave Reci<br>account for my personal use.  | pient listed above. I understand that a minimum  | n of one pay period of l                              | alance will be retained in my leav   |
|                        | of my sick/annual leave to the Leave Reci   | pient listed above. I understand that a minimum  | n of one pay period of t<br>Date                      | isor transfer the above listed nour<br>valance will be retained in my leav |
| Leave                  | Donor:  | pient listed above. I understand that a minimum  | n of one pay period of t Date                         | alance will be retained in my leav   |
|                        | Donor:  | the amount of leave to be donated in addition t  | n of one pay period of t Date                         | alance will be retained in my leav   |
| Leave                  | Donor:  | pient listed above. I understand that a minimum  | n of one pay period of t Date                         | alance will be retained in my leav   |
| Leave                  | Donor:  | pient listed above. I understand that a minimum  | n of one pay period of t Date to the required one pay | alance will be retained in my leav   |
| Leave<br>B.            | Donor:<br>I hereby certify that the donor has accrued<br>the donor's leave account.<br>ANNUAL LEAVE<br>SICK LEAVE   | pient listed above. I understand that a minimum<br>the amount of leave to be donated in addition t<br>Balance:             | Date Date PPE:  | alance will be retained in my leav   |
| Leave<br>B.            | Donor:  | pient listed above. I understand that a minimum<br>the amount of leave to be donated in addition t<br>Balance:             | Date Date PPE:  | alance will be retained in my leave  |
| Leave<br>B.<br>Payroll | Donor:<br>I hereby certify that the donor has accrued<br>the donor's leave account.<br>ANNUAL LEAVE<br>SICK LEAVE<br>Supervisor:<br>y certify for the Recipient Agency listed above | pient listed above. I understand that a minimum<br>the amount of leave to be donated in addition t<br>Balance:             | Date Date Date Date Date Date DPE: Date Date Date     | period leave which must remain in  |
| Leave<br>B.<br>Payroll | Donor:<br>I hereby certify that the donor has accrued<br>the donor's leave account.<br>ANNUAL LEAVE<br>SICK LEAVE<br>Supervisor:<br>y certify for the Recipient Agency listed above | pient listed above. I understand that a minimum<br>the amount of leave to be donated in addition t<br>Balance:<br>Balance: | Date Date Date Date Date Date DPE: Date Date Date     | period leave which must remain in  |