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GOVERNMENT OF GUAM
DEPARTMENT OF EDUCATION

SICK/ANNUAL LEAVE DONATION REQUEST FOR MEDICAL EMERGENCY REASONS

		LEAVE RECIPIENT	LEAVE DONOR
1.	EMPLOYEE NAME		
2.	SOCIAL SECURITY NO.		
3.	CLASS TITLE, PAY GRADE/STEP		
4.	AGENCY/DIVISION		

5. **DONATED LEAVE PERIOD:** **FROM - TO:** _____ **TOTAL HOURS:** _____

6. **EXPLANATION OF ILLNESS/INJURY:**

_____

_____

I hereby certify that I have secured permission from my agency to use donated sick/annual leave pursuant to the leave sharing procedures. This request is due to the above referenced illness/injury and will be used during the dates listed above in order to continue my compensation. I understand that my own accured leave will be exhausted first before the donated leave.

Certification of Leave: _____ **Date** _____

Recipient's Signature

7. **CERTIFICATION FROM LEAVE RECIPIENT'S PAYROLL SUPERVISOR**

A. I certify that the employee requesting for donated leave has accrued the following hours to his/her leave account.

☐	**ANNUAL LEAVE**	**Balance:**	_____	**PPE:**	_____
☐	**SICK LEAVE**	**Balance:**	_____	**PPE:**	_____
☐	**COMPENSATORY TIME**	**Balance:**	_____	**PPE:**	_____

Payroll Supervisor: _____ **Date** _____

8. **CERTIFICATION OF LEAVE DONOR**

A. I hereby certify that I am voluntarily donating the leave hours on item 5 above and request that my Payroll Supervisor transfer the above listed hours of my sick/annual leave to the Leave Recipient listed above. I understand that a minimum of one pay period of balance will be retained in my leave account for my personal use.

Leave Donor: _____ **Date** _____

B. I hereby certify that the donor has accrued the amount of leave to be donated in addition to the required one pay period leave which must remain in the donor's leave account.

☐	**ANNUAL LEAVE**	**Balance:**	_____	**PPE:**	_____
☐	**SICK LEAVE**	**Balance:**	_____	**PPE:**	_____

Payroll Supervisor: _____ **Date** _____

9. I hereby certify for the Recipient Agency listed above that this request meets the guidelines for donating sick/annual leave pursuant to the leave sharing procedures. I authorize my agency to add the total hours donated above to the recipient employee listed.

☐ APPROVED ☐ DISAPPROVED

Recipient's Appointing Authority _____ Date _____