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GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION

INSTRUCTIONS FOR COMPLETING FORM

SICK/ANNUAL LEAVE DONATION REQUEST FOR MEDICAL EMERGENCY REASON

1. Enter employee names, the Recipient first and then the Donor.

2. Enter the social security numbers for both employees.

3. Enter the classifications of the employees and the associated pay grade for each.

4. Enter each employee's Agency and Division.

5. Enter the dates for which the donated leave is to be used.

   Note: These dates must not be for a prior period of time as the request must be approved before leave can be taken. Also, enter the total hours and leave type to be used during this period of time (hours of leave donated).

6. Explain the appropriate reason (medical emergency) for which this leave will be used. The recipient employee must sign and date the form.

7. To receive leave, the requesting employee (recipient) must obtain certification from his agency payroll supervisor on his leave account.

8. The donating employee must certify this request by signing and dating the form. In addition, the donor employee must obtain certification from his payroll supervisor indicating 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.

   INSTRUCTIONS FOR RECIPIENT ON THE REQUIRED DOCUMENTATION

   A. The recipient shall attach a copy of the medical certification by a licensed practicing physician.

   B. Attach a copy of the approved Request for Leave (Form FCN 2-0-1). Note: Absence must be for a minimum of 10 consecutive work days for medical emergency reasons.

9. Recipient's Appointing Authority's certification.

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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. CERTIFICATION OF LEAVE RECIPIENT
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 because my leave will have exhausted prior to this request.

Leave Recipient: _____ **Date** _____

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** _____