RESEARCH CORPORATION
OF THE UNIVERSITY OF GUAM

LEAVE APPLICATION

Name: (First, Middle, Last)	Department/Unit:	Date: (MM/DD/YYYY)

Type of leave requested:
☐ Sick ☐ Annual ☐ Pregnancy, related medical
☐ Jury ☐ Military ☐ Parental
☐ Others (specify) _____

Pay Status:
Number of hours with: _____ Without Pay: _____ Total number of hours: _____

From: (hour, month, day, year)	To: (hour, month, day, year)

Reason (s):

Note: For rules and regulations pertaining to leaves and absence from duty, refer to the appropriate RCUOG personnel policies as approved by the Board of Directors.

DOCTOR'S SICK LEAVE CERTIFICATION
I certify that the above-named person was under my professional care or quarantined during the period stated below.

From: (hour, month, day, year)	To: (hour, month, day, year)	Hospitalized ☐ Yes ☐ No

Remarks: (state limitations, if any)

Name of Physician: (Print or Type)	Signature
I certify all statements made herein are true and correct.	Signature of Employee/Date
☐ Approved ☐ Disapproved	Signature of Supervisor/Chair/Date
☐ Approved ☐ Disapproved	Signature of Appropriate Administrator/Date

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