West Irondequoit Central School District

Cancer Screening Leave Request Form

Name: ______________________________ Date: ______________

Building: ______________________________

Position: ______________________________

Date(s) of requested screening:

Day(s) of Week	Month – Day (s) – Year	From - To

☐ Breast cancer screening

☐ Prostate cancer screening

The last screening I had was on ______________________ for:
(date)

☐ Breast cancer screening

☐ Prostate cancer screening

I understand that I have a maximum of four hours each school year for this screening including commute time for females or eight hours maximum annually for males. I understand this time is not cumulative. I understand this time is not compensable if screening takes place on a holiday or during my non-working hours. I understand and will provide proof of the screening.

______________________________ ____________
Employee Signature Date

______________________________ ____________
Approved by Executive Director of Personnel Date

For Office Use Only

Proof Received ____________

Date of Last Exam ____________

Verified ____________

Hours Used ____________

____
Doctor's Signature
[Proof of Attendance]

9/2007 revised 1/2008