

**SPENCERPORT CENTRAL SCHOOL DISTRICT
Human Resources Office**

CANCER SCREENING FORM

Name _____ Date _____

School or Department _____

Position _____

I attended an appointment on _____ AM / PM for my annual cancer screening. (date of screening) (circle one)

I understand I have a maximum of four (4) hours annually (including commute time). I understand this time is not compensable if screening takes place on a holiday or during my non-working hours.

I will report my absence, as I do when sick, and cite the reason as cancer screening. Additionally, I will provide this form or proof from the physician's office, with the physician's/authorized designee's signature, to the Human Resources office within ten (10) working days of the screening.

Please attach a copy of the verification of appointment from the physician's office detailing date, time, and type of screening with this form. Please fill out the bottom of this form if physician's office does not provide such verification.

Employee's signature Date

Physician's Statement:

Patient's name: _____

Date of screening: _____

Cancer screening: Yes No

Physician's/Authorized designee's signature Date

c: Medical File

For HR Office Use Only
Form Received _____
Date of Last exam _____
Verified _____
Hours Used _____