NIAGARA FALLS CITY SCHOOL DISTRICT
OFFICE OF HUMAN RESOURCES

CANCER SCREENING LEAVE REQUEST FORM – Page 1

Submit this form within 48 hours notice to Office of Human Resources

Cancer Screening Leave is excused leave, with pay. It is limited to:

A. Four (4) hours of leave annually (from July 1 to June 30) for breast cancer screening for employees,

and

B. Four (4) hours of leave annually (from July 1 to June 30) for prostate cancer screening for employees.

PLEASE PRINT

NAME _____

POSITION _____

LOCATION _____

DATE/TIME OF SCREEN APPOINTMENT _____ _____
date time

TIME REQUESTED OFF*: FROM _____**am/pm TO** _____ **am/pm**
(To be taken in one-hour increments)

***This time will not be charged against any other leave time, provided it does not exceed four hours annually. If cancer screening time exceeds four hours, the Office of Human Resources will use 1/2 day personal illness, 1/2 day personal business, or 1/2 day vacation for the second half of the day. If accrual time is not available, the employee will lose a half-day of pay.**

DOCUMENTATION:
The attached "Verification of Cancer Screening Appointment" form must be completed, signed by a representative of the medical facility and submitted to the Office of Human Resources within 72 hours after the cancer screening appointment.

_____ _____
Employee Signature **Date Submitted to HRO**

HRO Use Only - Employee charged 1/2 day personal illness _____ **(initial/date). To be returned to employee upon receipt of signed "Form 2 - Verification of Cancer Screening Appointment."**

VERIFICATION OF CANCER SCREENING APPOINTMENT FORM – Page 2

To be completed by the employee and submitted to the Office of Human Resources within 72 hours after the cancer screening appointment

Employee Name: _____

Position: _____

Location: _____

Gender: ☐ **Male** ☐ **Female** ☐ **NonBinary**

This is to verify that the above identified employee appeared

at: _____
(name of medical facility)

on: _____ **at:** _____
(date) **(time)**

for the purpose of screening for:

☐ **Breast Cancer** ☐ **Prostate Cancer**

To be completed by the Screening Facility:

Name of person at facility who can verify appointment:

Printed Name: _____

Signature: _____

Contact Telephone: _____

Physician Stamp: _____

HRO Use Only - Employee 1/2 day personal illness day reimbursed _____ **(initial/date)."**