ONC BOCES
CANCER SCREENING LEAVE PROCESS

Cancer Screening Leave Request Form

New York State Law entitles all district employees to take up to four (4) hours of paid leave annually without charge to leave credits. The screening includes physical exams specifically for the detection of cancer, including mammograms. Travel time is included in the four (4) hour cap. Absence beyond the four (4) hours must be charged to leave credits.

Please Print

Name: **Title:**
Date Submitted:
Department:
Gender: **_____ Male** **_____ Female**
Regular Hours of Work:
Date and Time of Screening Appointment: Date: _____ **Time: _____**
Leave Time Requested: From _____a.m./p.m. To: _____a.m./p.m. ***The time must not exceed four (4) hours. If leave time does exceed four (4) hours, you must use accrued sick, personal or vacation time.***
Supervisor Signature: **Date:**
Documentation Process: ***1. REQUEST FORM - This completed leave request form must be submitted to your supervisor one (1) week prior to your appointment for his/her signature.*** ***2. VERIFICATION FORM - The employee must fill out the Verification of Cancer Screening Appointment form attached and have it signed by a representative (Doctor, Nurse or Medical Office Personnel) of the screening facility. The completed form must be returned to the Human Resources Office.***

ONC BOCES
CANCER SCREENING LEAVE PROCESS

Cancer Screening Leave Verification Form
Submit the completed form to the Human Resources Office

New York State Law entitles all district employees to take up to four (4) hours of paid leave annually, without charge to leave credits, for cancer screening. The screening includes physical exams specifically for the detection of cancer, including mammograms. Travel time is included in the four (4) hour cap. Absence beyond the four (4) hours must be charged to leave credits.

Please Print

Employee Name:

Address:

Telephone Number:

Verification Information:

Medical facility/Name & Location: _____

Date: _____ **Time:** _____

for the purpose of screening for:

☐ _____

To be Completed by the Screening Facility:

Medical Facility Phone Number: _____

Printed Name: _____

Health Care Provided Signature: _____

Employee Signature: **Date:**

Documentation Process:
1. REQUEST FORM - This completed leave request form must be submitted to your supervisor one (1) week prior to your appointment for his/her signature.

2. VERIFICATION FORM - The employee must fill out the Verification of Cancer Screening Appointment form attached and have it signed by a representative (Doctor, Nurse or Medical Office Personnel) of the screening facility. The completed form must be returned to the Human Resources Office.