Sandy Creek Central School District

"Comet Pride is Community-Wide!"

Cancer Screening Leave Request

New York State Law entitles employees to take up to four hours of paid leave annually, without charge to leave credits, for breast cancer and prostate cancer screening. Travel time is included in the four-hour cap. Absence beyond the four hours must be charged leave credits. Employees who undergo screenings outside their regular work schedule do so on their own time.

To properly request this absence, please complete the information below. Return the completed for to your supervisor or Department Head for approval within ten (10) business days before the date on which you expect to be absent from work. Document the time off on your timesheet as and excused absence.

To be completed by employee (please type or print)

Employee Name:_____

Heath Care Provider:_____

Date of Service: _____

Time expected to be absent from work (including travel time):

From: _____ To: _____

I hereby certify that this request for time off from work is for the purpose of obtaining a breast and/or prostate cancer screening pursuant to Section 159-b and/or 159-c of the New York State Civil Service Law.

Signature of Employee: _____

Date:_____

Approved: _____ Date: _____
Signature of Department Head

If request for leave is denied, please set forth the reasons:

_____

_____

_____

P.O. Box 248, 124 Salisbury Street, Sandy Creek, NY 13145 • (315) 387-3445; Fax (315) 387-2196

Please detach and return this certification to the Personnel Office within **ten (10)** days of your cancer screening in order to receive payment for your screening as an excused absence. If necessary, forms can be faxed to (315) 387-2196. If mailing this certification, please send to:

Sandy Creek Central School District
P.O. Box 248
124 Salisbury Street
Sandy Creek, NY 13145

Certification of Health Care Provider

_____
Patient Name (Please Print)

This is to certify that I have provided a breast and/or prostate cancer screening of the individual listed above on _____ (date) at _____ (time).

Signature of Health Care Provider: _____

Date:_____