

Putnam Valley Central School District

146 Peekskill Hollow Road
Putnam Valley, New York 10579

Cancer Screening Request for Release Time Breast or Prostate Cancer

Date of Request: _____

Employee's Name: _____

Date of Screening: _____ Time of Appointment: _____

Total Time Requested: _____

Approved: Yes No

Supervisor's Approval: _____ Date: _____
(Signature)

Note:

The employee must have the attached verification form signed by the attending medical technician at the time of the screening appointment, and return it to their Supervisor in order for this leave to qualify as paid time. A maximum of four (4) hours per year may be granted for this purpose, and only for time that conflicts with an employee's normal working hours.

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Verification of Cancer Screening Visit

Name of Patient: _____

Address: _____

Date of Appointment: _____ Time: _____

Purpose of Appointment: Breast Screening

 Prostate Screening

Screening Provider Name: _____

Address: _____

Person signing below verifies that the employee named herein attended the above scheduled appointment for the purpose of receiving a breast or prostate screening test.

Signature of Medical Technician Performing Test

Title