CLARENCE CENTRAL SCHOOL DISTRICT
Verification of Cancer Screening

To be completed by employee:
(please print all information)

Name: _____ Telephone: _____

Address: _____

City/State/Zip:_____

Date of Birth: _____

To be completed by service provider:

This verifies that the above named individual appeared at:

_____
(Name of Provider)

on: _____ at _____ a.m./p.m.
(Date) *(Time)*

Print Name: _____

Signature: _____

Telephone: _____ Physician's Stamp: