



CLARENCE CENTRAL SCHOOL DISTRICT

Cancer Screening Leave Request

Please print all information

Name:	Today's Date:
Building:	
Date and Time of Screening Appointment: Date: _____ Time: _____	
I am requesting cancer screening time: from _____ a.m./p.m. to _____ a.m./p.m.	
It is my understanding that time charged to this screening benefit is limited to four (4) hours per calendar year. If my absence exceeds four (4) hours, I will be charged either sick, compensatory, personal or vacation time, in that order to ensure no loss of pay for the day. If no accrued time is available for use, pay for the day will be limited to four (4) hours.	

It is further my understanding that I must return the completed *Verification of Cancer Screening* form to the secretary designated in my building.

Employee Signature: _____ Date: _____

Principal Signature: _____ Date: _____