

MORAVIA CENTRAL SCHOOL

CANCER SCREENING LEAVE REQUEST FORM

I am submitting this form as I have undergone a cancer screening exam.

Date of Appointment _____

Duration of Appointment _____

Duration of Travel Time _____

Name and address of medical office _____

Signature _____
(Doctor, Medical Office Personnel, or Nurse)

Date _____

I affirm that the statements made on this form are true and correct under the penalty of law.

(Employee Signature)

(Date)

(Employee - Print Name)

You are allowed to take four hours from your work day per school year for screening without having to use any allotted sick time.