

CANCER SCREENING LEAVE FORM

To be completed by employee (please type or print)

Employee Name: _____

Screening type: Breast Cancer
(check one) Prostate Cancer

Health Care provider: _____

Date of Service: _____

Time out of work from: _____ to: _____
(including travel time)

To be completed by Health Care Provider

This is to certify that I provided health care services as noted above
for the purpose of cancer screening as noted above.

Signature of Health Care Provider Date