



## Cancer Screening Leave Form

*To be completed by employee (please print)*

Employee Name: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Time Out of Work (including travel time): From \_\_\_\_\_ To \_\_\_\_\_

*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.

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date