PURCHASE COLLEGE STATE UNIVERSITY OF NEW YORK
CANCER SCREENING LEAVE FORM*

TO BE COMPLETED BY EMPLOYEE (PLEASE TYPE OR PRINT)

EMPLOYEE NAME:
HEALTH CARE PROVIDER:
TIME AWAY FROM WORK (INCLUDE 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 as noted above.

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Signature of Health Care Provider

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Date

*Please submit the completed form to the Department of Human Resources only.