Leave for Cancer Screening

The New York Legislature has amended the current cancer screening law providing that public employees are entitled to excused leave for up to four (4) hours annually for the purpose of cancer screening procedures.

The leave will be considered to be paid leave, unless either a governmental authority or a court of law declares that the leave is unpaid under the New York State statute. Such leave will not be deducted from accrued sick leave or any other accrued leave.

The entitlement is for up to four (4) hours of leave annually. If an employee is absent for more than four (4) hours on the date of the screening, then the time will either be unpaid or charged to an appropriate category of leave (if the employee has any such leave accrued).

Documentation is required. An employee using this leave entitlement must have either a signed statement from the cancer screening facility, or our District form stamped by the medical provider that verifies the purpose of the leave. A Verification of Cancer Screening or Blood Donation form is attached, and additional copies will be available online at www.saratogaschools.org – Personnel Development – Forms, and at the Office of Personnel Development. Completed forms should be returned to Annetta Dunham in the Personnel Development Office.

The leave must also be noted as “Cancer Screening” in AESOP for all employees and appropriately reported on time sheets.

Rev. March 1, 2019
Saratoga Springs City School District
Office of Personnel Development

Verification of Cancer Screening or Blood Donation

To be completed by employee (please print legibly):

Employee Name: ____________________________ Position: ____________________________

Building: ____________________________ Telephone: ____________________________

This is to verify that I appeared at ____________________________ (Name of Facility or Physician’s Office)
on: ____________________________ from __________ to __________ (a.m./p.m.)
(Date)

for the purpose of:

☐ Cancer Screening (Up to 4 hours)
☐ Blood Donation (Up to 3 hours)

Employee Signature: ____________________________ Date: ____________________________

To be completed by the Medical Provider or Blood Donation Facility:

________________________________________ was seen for the purpose of:

(Name)

☐ Cancer Screening
☐ Blood Donation

on: ____________________________ (date) at: ____________________________ (time)

Physician’s Printed Name or Stamp: ____________________________________________

Name & Location of Blood Donation Facility, if applicable: ____________________________

Physician’s or Provider’s Signature: ____________________________ Phone: ____________________________

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