

**Excused Leave for Mammography and Prostate Screening
Request Reimbursement for Time Taken**
(Time taken for this purpose is not to exceed four hours each academic year.)

I. To be completed by employee.

Employee Name:

Department:

I am requesting that the __ hours which I charged to my sick / personal time bank be restored in accordance with the Excused Leave for Mammography and Prostate Screening New York State Legislature.

Employee Signature:

Date:

II. To be completed by employee's healthcare provider.

Date of Screening:

Health Care Provider Name:

Type of Practice:

Address:

Health Care Provider Signature:

III. For HR use only.

Number of Hours
returned:

To: Sick time bank
 Personal time bank

Date:

By:

Office of Human
Resources