

Dobbs Ferry Union Free School District

CONFIDENTIAL

Complete Part 1 and have Part 2 completed by your physician. Mark your Request for Absence in Absence Management (formerly AESOP) as “screening” for the time taken. Sign the bottom portion of this form and return it to the Personnel Office prior to the end of the pay period after your appointment. If you have questions related to this request for excused absence, please contact the Personnel Office.

Part 1 - To be completed by employee:

Name:(please print) _____

Date of Screening: _____

Please check which type of excused medical leave you are requesting:

- ☐ Breast Cancer Screening (max 4 hours annually)
- ☐ Prostate Cancer Screening (max 4 hours annually)

Part 2 - To be completed by employee's physician or health care provider

Employee Name: _____

Date of Visit: _____ at (time of appt.) _____

By (Physician Name or Medical Facility - print):

Physician Signature or Medical Facility Stamp _____

Employee Signature: _____ Date submitted: _____