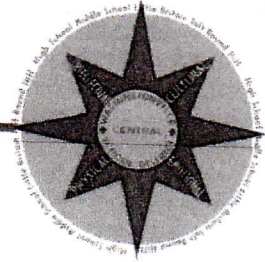


# WASHINGTONVILLE CENTRAL SCHOOL DISTRICT

52 West Main Street, Washingtonville, New York 10992



## Verification of Cancer Screening Appointment

To be completed by employee:

Employee Name: _____
Date of Birth: _____
Address: _____
Telephone Number: _____
This is to verify that the above identified employee appeared
at: _____ (name of facility)
on: _____ (date)
at: _____ (time)
for the purpose of screening for:
<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Prostate Cancer
<b>To be completed by the Screening Facility:</b>
Name of person at facility who can verify appointment: _____
Printed Name: _____
Signature: _____
Contact Telephone: _____
Physician Signature/Stamp: _____

*The Washingtonville Central School District is committed to the intellectual, cultural, physical and emotional growth of our children in a safe and supportive environment.*