BYRON W. BROWN
MAYOR

CITY OF BUFFALO

DEPARTMENT OF HUMAN RESOURCES
Compensation and Benefits Division

Gladys Herndon-Hill
ACTING COMMISSIONER

Antoinette Palmer
DIRECTOR

POLICY LEAVE FOR BREAST CANCER & PROSTRATE CANCER SCREENING

City of Buffalo employees are entitled to paid excused leave from work to undertake screening examinations for breast and prostate cancer. Such excused leave shall not exceed four (4) hours for breast and/or prostate cancer screening on an annual calendar year basis. This paid excuse leave shall not be charged against any other leave time which an employee may otherwise be entitled.

All employees taking time off for screening purposes are required to provide their Department Head or designee with sufficient notice in order to address staffing considerations.

Employees are required to provide medical documentation to their Department Head or designee that their absence is for breast or prostrate screening purposes.

Reference: Civil Service Law, Section 159-6 and 159-c, as amended.

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CITY OF BUFFALO
CANCER SCREENING LEAVE REQUEST

Pursuant to Section 159-b and/or 159-c of the New York State Civil Service Law, employees are entitled to take up to four hours of paid leave annually, without charge to leave credits, for both breast and prostate cancers screening. Travel time is included in the four-hour cap. Absence beyond the four hours must be charged to leave credits. Employees who undergo screening outside their regular work schedule do so on their own time.

To properly request this absence, please complete the information below, including a signature from the provider's office and document the time off on your timesheet as an excused absence.

To be completed by employee (please type or print):

Employee Name: _____

Health Care Provider: _____

Date of Service: _____

Time expected to be absent from work (including travel time):

From: _____ To: _____ Date: _____

I hereby certify that this request for time off from work is for the purpose of obtaining a breast and/or prostate cancer screening.

Employee Signature: _____ *Date:* _____

Department Head signature: _____ *Date:* _____

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CERTIFICATION OF HEALTH CARE PROVIDER

Patient Name: (Please print)

This is to certify that I have provided a Cancer screening of the individual listed above on _____ (date)

Check here if screening was (please circle one)

- Breast Cancer Screening
- Prostate Cancer Screening

Signature of Health Care Provider: _____ *Date:* _____

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