



**Office of Human Resources  
Confidential**

**Employee Request for Excused Medical Leave**

Directions: Complete Part 1 and have Part 2 completed by your physician. If you are calling for a substitute, please indicate “screening” or “donation” for the time taken. If your department does not use the substitute calling service, mark your timesheet as per above. Sign the bottom portion of this form and return it to the staff person responsible for your payroll prior to the end of the pay period after your medical appointment. If you have any questions related to your request for excused medical leave, please contact Human Resources at 399-9141 ext. 85035.

**Part 1 - To be completed by Employee:**

**Employee Name** \_\_\_\_\_ **Date** \_\_\_\_\_  
(please print) (of screening or donation)

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

- Breast cancer screening (max 4 hours annually) \_\_\_\_\_  
# of hours taken for this appointment \_\_\_\_\_
- Prostate cancer screening (max 4 hours annually) \_\_\_\_\_  
# of hours taken for this appointment \_\_\_\_\_
- Blood donation (max 3 hours annually) \_\_\_\_\_ (effective 12/13/2007)  
# of hours taken for this appointment \_\_\_\_\_

**Part 2 - To be completed by employee’s physician or blood donation facility:**

\_\_\_\_\_ was seen on \_\_\_\_\_  
**Employee name (please print)** **date (mm/dd/yyyy)**

at \_\_\_\_\_ o’clock by \_\_\_\_\_  
**time of appt.** **Physician name OR Medical Facility (please print)**

\_\_\_\_\_  
Physician or authorized representative’s signature

\_\_\_\_\_  
Employee’s Signature

\_\_\_\_\_  
Date submitted