

CLARENCE CENTRAL SCHOOL DISTRICT

Verification of Cancer Screening

To be completed by employee:

(please print all information)

Name: _____ Telephone: _____

Address: _____

City/State/Zip: _____

Date of Birth: _____

To be completed by service provider:

This verifies that the above named individual appeared at:

(Name of Provider)

on: _____ at _____ a.m./p.m.
(Date) (Time)

for the purpose of (mark one):

Breast Cancer Screening Prostrate Cancer Screening

Print Name: _____

Signature: _____

Telephone: _____ Physician's Stamp: