Cumberland County Employee Wellness Services

Employee Wellness Center Clinic

VISIT AUTHORIZATION/RETURN TO WORK NOTICE

Employee's Name: _____

Department: _____

Date: _____ **Supervisor's Signature_____**

Jobsite check-out time: _____

Clinic check-in time: _____ **Clinic check-out time: _____**

May return to work: _____

Provider's or RN's Signature:_____

Pharmacy check-out time: _____ Pharmacist's/Pharmacy Tech's Signature:_____

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