Cumberland County Employee Wellness Services
Employee Health Center

VISIT AUTHORIZATION/RETURN TO WORK NOTICE

Employee Name ______________________________

Department ______________________________

Date ______________ Supervisor Signature ______________________________

Jobsite Check-Out Time ______________

Clinic Check-In Time ______________ Clinic Check-Out Time ______________

May return to work ______________

Provider or RN Signature ______________________________

Pharmacy Check-Out Time ________ Pharmacist/Pharmacy Tech Signature ______________

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