JHHSC/JHH Employee Health & Wellness Center
600 N. Wolfe Street, Phipps 3rd Floor
Baltimore, MD 21287

NAME: ______________________________ **BADGE NUMBER**________________________

DEPT: _______________________________ **DATE & TIME:** _______________________________

TO BE COMPLETED BY SUPERVISOR

The above employee has my permission to visit the Health & Wellness Center on the above date and time.

__________________________________ __________________________________
Supervisor's Name **Department**

__________________________________ __________________________________
Date **Telephone #**

Note: This form is not valid for individuals who have filed a claim or are currently receiving benefits under workers compensation for on-the-job injuries or illnesses. Such individuals are required to have their disability status assessed by the Johns Hopkins Occupational Injury Clinic.