

**CITY OF LAKELAND
AUTHORIZATION TO ATTEND HEALTHSTAT WELLNESS CLINIC**

Employee's Name: _____ City ID #: _____
Not Social Security #

DOB: _____ Dept/Div: _____

Date/Time of Clinic Appointment: _____

Appt. Authorized by: _____
Supervisor's Name – Printed Supervisor's Signature/Date

Time Leaving Workplace: _____ a.m./p.m.

This portion to be completed by HealthSTAT staff only

Clinic Time In: _____ a.m./p.m. Clinic Time Out: _____ a.m./p.m.

HealthSTAT Personnel Signature: _____

Time Returned to Workplace: _____ a.m./p.m.

Total Hours: _____ Payroll Code: _____

**PLEASE RETURN THIS FORM TO YOUR PAYROLL TIMEKEEPER FOR RECORDING
PURPOSES.**