

# EMPLOYEE HEALTH STIPEND

## Payroll Authorization Sheet

EMPLOYEE NAME:

EMPLOYEE ID:

DEPARTMENT:

PAY PERIOD:

SUBMISSION DATE:

JOB TITLE:

EXPENSE DATE	WELLNESS CATEGORY / DESCRIPTION	RECEIPT (Y/N)	AMOUNT REQUESTED
<b>Total Reimbursement Amount Requested:</b>			

**Wellness Stipend Policy Agreement:**

By signing below, the employee certifies that all expenses listed above were incurred for personal health and wellness purposes in accordance with the company wellness program guidelines. Original receipts must be attached for all requested reimbursements. Approved reimbursements will be processed in the upcoming payroll cycle and are subject to applicable tax withholdings.

EMPLOYEE SIGNATURE

DATE:

MANAGER APPROVAL SIGNATURE

DATE:

HR / BENEFITS SIGN-OFF

**DATE:**

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**PAYROLL PROCESSING AUTHORIZATION**

**DATE:**