NAME __________________________ PHONE # __________________
E-MAIL ________________________________

*Please fill out the section below for .5 wellness point.
Hike must be 5+ miles roundtrip with an elevation change of at least 500 ft. You may count a maximum of 2 hikes for 2 points.

Blood Drive Location ________________________________ Date _______________
Signature of Blood Drive Official ________________________ Date _______________

Blood Drive Location ________________________________ Date _______________
Signature of Blood Drive Official ________________________ Date _______________

OTHER COMMUNITY EVENT (Must receive PRIOR authorization from HR)
Event Name _______________________________________ Date _______________
Signature of Other Event Official ________________________ Date _______________

OTHER COMMUNITY EVENT (Must receive PRIOR authorization from HR)
Event Name _______________________________________ Date _______________
Signature of Other Event Official ________________________ Date _______________

I certify that the above information is correct.
___________________________________ Signature _____________ Date