

Certificate of Participation



This certificate is awarded to:

Name of Recipient

In recognition of _____ hours/points of completion in the Worksite Wellness Program

Agency Director

Date

Wellness Coordinator

Date





State of Wyoming Department of _____

In recognition of the Department of _____
Worksite Wellness Program- has
completed _____ hours/points.

Excellence
Award

Name of Participant



Worksite Wellness
Participant

Has received four (4)
hours of Administrative
Leave

Signature _____

_____ Date

Signature _____

_____ Date