COMPLAINT FORM

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS AND CHILDREN

ALL COMPLAINTS (EXCEPT DISCRIMINATION COMPLAINTS) SHOULD BE SENT TO:
THE BUREAU FOR PUBLIC HEALTH,
OFFICE OF NUTRITION SERVICES/WIC PROGRAM
350 CAPITOL STREET, ROOM 519
CHARLESTON, WEST VIRGINIA 25301-3717

COMPLAINT AGAINST VENDOR:

VENDOR NAME AND ADDRESS: _____

_____

_____

COMPLAINT AGAINST PARTICIPANT

PARTICIPANT NAME: _____
LOCAL AGENCY NAME: _____

COMPLAINT AGAINST LOCAL AGENCY:

LOCAL AGENCY NAME: _____
CLINIC SITE: _____

NARRATIVE (PLEASE GIVE DETALS OF COMPLAINT SUCH AS WHO, WHAT, WHEN, WHERE AND WHY – CONTINUE ON BACK IF NECESSARY):

I, THE UNDERSIGNED, DO HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____

SIGNATURE OF COMPLAINTANT DATE

COMPLAINT RECEIVED BY: _____

ACTION TAKEN (CONTINUE ON BACK IF NECESSARY); _____

_____

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