

Please complete and return the following information listed below. Please send the information to the requesting clinic as soon as possible.

DU/Clinic:

Name:

WIC ID: _____

Birth date:

Parent/Guardian' s Name:

Date of last voucher pickup:

Date of Issue:

Is this client active or terminated?

(If terminated, indicate term date and term code)

Termination Date: Term code:

Has the client transferred into your area recently?

(If yes, give date; _____)

Date of last certification:

Participant' s Social Security number:

Revised 03/14