



**Georgia's Special Supplemental Nutrition
Program for Women, Infants, and Children (WIC)**

Dual Participation Request For Investigation Form

Please complete and attach to the Dual Participation Composite Report by the 15th of each month.

District/ Clinic: _____

Client's 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: _____