DEPARTMENT OF HEALTH
WIC State Agency
Government of the District of Columbia

PARTICIPANT COMPLAINT REPORT CONCERNING VENDOR

Instruction: Complete this form in blue or black ink. Mail, fax or email to: Vendor Manager, WIC Program; 899 North Capitol Street, NE, 3rd Floor, Washington, DC 2002; Fax (202) 535-1710; email : info.wic@dc.gov

Date of Incident: _____ **Date Incident was filed:** _____

PERSON FILING COMPLAINT:

Name (optional): _____ **WIC ID# (optional):** _____

Name of Participant's Clinic: _____

Participant's phone#: (h) _____ **(w)** _____

STORE THE COMPLAINT IS ABOUT:

Store name: _____

Address: _____

Phone # _____ **Other:** _____

Number of times participant returned to store to rectify the problem: _____

DETAILS OF COMPLAINT:

Please list specific information: _____

_____

_____

_____

STATE AGENCY FOLLOW-UP:

Staff Name: _____ **Date & time:** _____

Store's perception of problem: _____

_____

Corrective Action Taken: _____

_____

Date Status Report given to participant or local agency: _____

Store Sanctioned: ☐ **Yes** ☐ **No**

This institution is an equal opportunity provider.