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.