Clinic Name: _____

Address: _____

City, State, Zip: _____

Phone #: ( ) _____ **Fax #:** ( ) _____

Idaho State WIC
1-800-942-5811

Issue Date: _____ **Time:** _____

VERIFICATION OF CERTIFICATION

Participant Name: _____ Idaho WIC ID: _____

Category: _____ Priority: _____

Begin Certification Date: _____ Certification End Date: _____

Income Eligibility Date: _____

Period of Benefits Issuance: _____

Nutrition Risks (include both code and title): _____

_____

_____

Printed Staff Person Name: _____

Staff Person Signature: _____

This institution is an equal opportunity provider.
Esta institución es un proveedor que ofrece igualdad de oportunidades.