



# WIC FORMULA REPLACEMENT FORM

Parent Guardian/Caretaker Name:	Clinic:	Date:
Participant Name:	Participant ID:	
Participant Name:	Participant ID:	

Please describe what happened:

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**FORMULA REPLACEMENT AGREEMENT:**

Please read the information below. You must sign before you can receive replacement formula benefits.

- Reason formula is being replaced:
  - Fire       Flood       Natural Disaster
  - Not available for use (please describe) \_\_\_\_\_
  - Not given to me by the previous caregiver \_\_\_\_\_  
(previous caregiver's name)
- I will bring the original formula back to the clinic if I am able to reclaim it or it is given to me by the previous caregiver.
- I understand if I give false information to receive more formula than allowed per month, I have broken WIC rules. I will have to pay the money back to WIC and I can be taken off the Program.

**"I certify, with my signature below, under penalty of perjury under the laws of the State of Washington that the above statement is true and correct to the best of my knowledge."**

Parent Guardian/Caretaker Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of WIC staff: \_\_\_\_\_ Date: \_\_\_\_\_

Form Distribution: Scan form into Cascades and give original to the participant, parent guardian or caretaker.

This institution is an equal opportunity provider.  
**Washington State WIC Nutrition Program does not discriminate.**

To request this document in another format, call 1-800-841-1410.  
Deaf or hard of hearing customers, please call 711 (Washington Relay)  
or email [civil.rights@doh.wa.gov](mailto:civil.rights@doh.wa.gov).

