

REQUEST TO EXTEND LOCAL AGENCY WIC SERVICE AREA

The _____ agency/clinic serves WIC client(s):

Name: _____

Name: _____

Name: _____

From _____ County for the following reasons:

(Check all that apply)

- ___ 1. Client(s) receive health care at the _____ clinic.
- ___ 2. Client(s) live closer to the _____ clinic.
- ___ 3. Other (please specify): _____

Local Agency WIC Program Representative	Date	Local Agency WIC Program Representative	Date
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A copy of the completed and signed form must be kept in a central file at both local agencies.

Comments: _____

