WIC Formula Drop Ship Order Form

To be completed by WIC clinic:

LA/Clinic #: _____ Clinic Phone #: _____ Date of Order: _____

Clinic Contact (print name): _____ Benefit Month: _____

Participant Name: _____DOB: _____ PAN: _ _ _ _-_ _ _ _ -_ _ _ _ -_ _ _ _ -_ _ _

Vendor Store Name: _____ Vendor Phone #: _____

Vendor Representative Contacted: _____ Vendor Fax #: _____

Formula Requirements:

Name	Size & Form	Code	Quantity	Unit Price
Shipping Charge				

Ship to clinic/other address*:

_____

_____

_____

Special shipping instructions:

_____

_____

_____

*State Agency approval REQUIRED for shipments to non-LA/Clinic address

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To be completed by vendor: WIC ACCOUNT #:_____ OUTLET #: _____

UPC #	Pkg (e.g. can, case)	Pkg Price	Qty Shipped	Claim Price
Date Shipped:	Vendor Ref/Order #	Total Formula Cost:		
Vendor Signature:		Shipping and Handling:		
		Total Cost:		

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To be completed by LA/Clinic staff receiving and storing ordered formula(s):

Date shipment received: _____ Initials: _____

LA/Clinic: After formula is received at the clinic, contact family to collect formula and obtain signature.

_____

Signature of Client/Parent/Guardian Receiving Formula Date

LA/Clinic: FAX signed form to vendor when all shipments have been issued/signed for by the parent/guardian.

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Vendor: *When form has client signature, please mail to* **WIC Program – FIRS Unit 4616 W. Howard Lane – Suite #275 Austin, TX 78728**	**For State Use**	
	Claim File Name:	*Promo/Claim#:*