

# FARMERS MARKET NUTRITION PROGRAM COMPLAINT FORM

Agency/Clinic Name: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Farmers Market: \_\_\_\_\_

## PERSON FILING COMPLAINT:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> WIC participant    | <input type="checkbox"/> Grower        |
| <input type="checkbox"/> Senior participant | <input type="checkbox"/> WIC/AAA Staff |
| <input type="checkbox"/> Market Manager     |  |
| <input type="checkbox"/> Other: _____       |  |

## DESCRIPTION OF COMPLAINT:

Date of Incident: \_\_\_\_\_

Time of Day: \_\_\_\_\_

Name or description of person(s) involved:

Describe the incident in detail:

Follow-up action taken:

**Mail this form to:**

Department of Health  
WIC Farmers Market Nutrition Program  
PO Box 47886  
Olympia, WA 98504-7886  
Phone: 1-800-841-1410

**Or, give form to:**

Market Manager  
Local WIC FMNP Coordinator  
Local Senior FMNP Coordinator