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| **New Jersey Department of Health**  **WIC Services/FMNP-SFMNP/CSFP** COMPLAINT REPORT ***INSTRUCTIONS: Person(s) making the complaint must complete Sections I through IV, retain a copy, and email/fax the original copy to the State Agency.***  ***Follow up action (as determined by the State Agency) must be documented in Section V.*** | | | | | | | FOR STATE USE ONLY |
| Initial Review by  Supervisor (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Assigned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Complaint #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **SECTION I** | | | | | **SECTION II** | | |
| **Who is making this complaint?**  Participant  Vendor  Farmer  Food Bank  Agency Staff  Local Agency | | | | | **Who is this complaint against?**  Participant  Vendor  Farmer  Food Bank  Agency Staff  Local Agency | | |
| Name | | | | | Name of Store or Participant | | |
| Street Address | | | | | *(If Store)* Address | | |
| City, State, Zip Code | | | Telephone No. | | *(If Participant)* ID No. | Name of Local WIC, SFMNP or Food Bank | |
| SECTION III ‑ DETAILS OF COMPLAINT | | | | | | | |
| Date of Incident | | Time of Incident | | Physical description of person(s) involved (height, weight, age, race, etc.): | | | |
| Description of What Happened (be as detailed as possible) *(Attach additional sheet if needed)*: | | | | | | | |
| SECTION IV ‑ CERTIFICATION ***I certify that the above information is true and complete to the best of my knowledge.*** | | | | | | | |
| Name of Complainant *(Type or Print)* | | | | | Title *(if any)* | | |
| Signature | | | | | | Date | |
| Name of Witness, if Any *(State)* | | | | | Title *(if any)* | | |
| Signature | | | | | | Date | |
| SECTION V ‑ TO BE COMPLETED BY STATE OR LOCAL AGENCY | | | | | | | |
| *(If complaint is anonymous or on behalf of another)* | Name of State or Local Agency Staff Person *(Type or Print)* | | | | | Signature | |
| Title *(if any)* | | | | | Date | |

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