

**Bureau of Health Services
COMPLAINT FORM**

County: _____ Clinic #: _____ Date: _____

Complaint filed by: Participant Retail Vendor

Name of Participant or Vendor **filing this complaint:** _____

Address, City, State, Zip: _____

Telephone Number: _____

Name of participant or vendor complaint filed **against:** _____

Address, City, State, Zip: _____

Nature of Complaint:

Local Response:

Project Staff Signature: _____ Date: _____

Complaints must be forwarded to: **Vendor Operations Section, Ohio Department of Health, Bureau of Health Services, 246 N. High St. – 6th floor, Columbus, OH 43216-0118.**

STATE WIC RESPONSE ONLY: