**ARAKANSAS DEPARTMENT OF HEALTH**

**WIC PROGRAM**

**COMPLAINT FORM**

<table>
<thead>
<tr>
<th>Complaint Against</th>
<th>Name of Complainant</th>
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<tbody>
<tr>
<td>Street Address</td>
<td>HHID#</td>
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<tr>
<td>City</td>
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**Complaint:**

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**Remarks:**

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Received by / Referred to / Date

**Disposition:**

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