NEBRASKA WIC CERTIFICATION DATA FORM

Agency	Clinic	Client ID	Family ID	Action Date	Initial Visit	Transaction	WL	Term	Term Date
260/00	05/00	329242	H31636	09/06/02	09/06/02	1			

1st Auth. Rep. Last Name	First Name	Phone Number	Alternate Phone Number
SMITH	MOM	(402) 471-2781	- -NONE

Address, Street, RFD, PO Box	City	State	Zip Code
123 MAIN	LINCOLN	NE	68506

Client Last Name	Client First Name	MI	Client Maiden Name
SMITH	BABY	B	

ADJ Elg.	HH Size	Annual Income	Int	PU Day	Status	Foster Child	Other Programs	Date of Birth	Social Security Number	Sex	Lang
N	4	14400	2	00	IFF	N		06/01/02	000-00-0000	F	S

Race	R/M/H	SRC Care	HS
H	X	P	N

ALLW	LMP	Est. Due Date

IC	Birth Wt.	Infant Food Package		
		4 mo. pkg	6 mo. pkg	12 mo. pkg
	/			

Signature of person assigning food pkg. Date

Status	Date of Cert.	Medical Date	Age		Height	Weight	HGB	HCT	Nutrition Risk Factors	PR	HR
			Yr.	Mo.							
IFF	06/24/02	06/24/02	00	00	21:0	008:00	99.7	.	7A	02	N

	Primary Vendor	Food Pkg	Secondary Vendor	Food Instr.	Secondary Vendor	Food Instr.	Secondary Vendor	Food Instr.
Initial Pkg.	6060	121						
Change #1								
Change #2								

Signature of person assigning food pkg. Date

Signature of person assigning food pkg. Date

397-013