NEW YORK STATE
DEPARTMENT OF HEALTH
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NYS WIC

VB #10 – August 27, 2014

NYS WIC PROGRAM

V E N D O R   B U L L E T I N

Title: Vendor Stamp Requests

This is an important notice. Please have it translated.

Este aviso es importante. Haga que lo traduzcan.
यह एक महत्वपूर्ण सूचना है। कृपया इसे अनुवाद करके रखें।
Это важное сообщение. Пожалуйста, попросите перевести вам данную информацию
這是一項重要通告。請予以翻譯。
Đây là thông báo quan trọng. Xin vui lòng nhờ người chuyển ngữ tài liệu này cho quý vị ‹ .
هذه ملاحظة هامة يرجى ترجمتها
Ovo je važna obavijest. Molimo da tražite da vam se prevede.
זוהי הודעה חשובה. נא לתרגם אותה.

The Vendor Stamp Request Form has been updated and a copy of the new version is attached for your use **when necessary**. The attached form supersedes ALL previous versions. This form must be used when requesting a vendor stamp.

An explanation for a vendor stamp is now required for processing. Your request will be thoroughly reviewed and may or may not be approved. If your request is disapproved, your check or money order will be returned to you promptly.

Only New York State (NYS) issued stamps may be used. You **must not** duplicate your stamp in any way. Your stamp **must** be maintained on the premises during operating hours and **must** produce a clear legible number. If your stamp cannot be cleaned, is worn or broken, it **must** be returned to NYS at the address noted on the request form.

The WIC Vendor Stamp issued to you is the property of NYS Department of Health WIC Program and must be immediately surrendered to your contracted Vendor Management Agency (VMA) upon expiration or termination of your contract.

If you have questions about this information, please contact your VMA.

Thank you for your participation in the NYS WIC Program.

This institution is an equal opportunity provider.

VENDOR STAMP REQUEST FORM

Date of Request: ______/______/________

WIC Vendor Stamp #: ________________

Request Made By: ____________________________________ ________________________________
Print Name Print Title/Position

____
Signature

Explanation of the request for a vendor stamp is required: ______________________________________

____

____

Store Trade Name: ____
Print Store Trade Name

Store Address: ____ *(Must be a physical address. Stamps will NOT be delivered to a PO Box.)*

____

____

Store Telephone Number: __________________________________

__________ **X $10.00 each = $** ________________
Quantity Total Amount (**Payable to: New York State Department of Health**)

Mail this completed request AND check or money order to:

New York State Department of Health
Food Delivery & Vendor Management Section
150 Broadway, Suite 512
Albany, New York 12204-2719

Include Stamp Impression Below

FDVMS Use Only: *Approved* ☐ *Disapproved* ☐ ____

____ ______/______/________
Contract Manager Signature Date

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