Bureau of Supplemental Food Programs, WIC Program

Non-Pharmaceutical Exempt Formula Application

Date:	Vendor ID #:

Corporation Name	
Store Trade Name	

Physical Location	Street:		
City		State:	Zip:
☐ Check box if Physical Location is the same as Mailing Address, otherwise complete below section.			
Mailing Address	Street:		
State:		State:	Zip:
Store Telephone #			
Store Email Address			

Indicate by check mark that your store meets each of the following requirements :	
☐	Five or more NYS WIC authorized stores. Provide exact number of stores: _____
☐	Three or more operating cash registers at the vendor location. Provide exact number of registers: _____
☐	Authorized WIC Vendor for a minimum of 12 months. Date of Authorization: ____ / _____ / _____
☐	Has not been non-renewed, terminated, sanctioned or disqualified by the WIC Program within the last 36 months.
☐	Agree to comply with an annual audit, which includes providing proof of formula purchases (valid purchase slips/invoices from an approved formula supplier).
☐	Agree NOT to redeem or cash checks for medical formulas that are excluded from this exemption.

Failure to meet ALL the above requirements will result in denial of your request for authorization to provide exempt formulas through the WIC Program.

Program violations or failure to comply with annual audit requirements, or failure to provide sufficient documentation during an audit will result in revocation of Exempt Formula Authorization.

I affirm that I am authorized to represent and legally bind the organization above and that the information provided in this application is true and agree to terms as described.	
Name (print):	Title:
Signature:	Date:

Send to:
NYS Department of Health
Division of Nutrition - BSFP/FDVMS
Riverview Center - Room 650
150 Broadway
Albany, NY 12204-2719

4/2016