Bureau of Supplemental Food Programs, WIC Program

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:		
City:		State:	Zip:
Store Telephone #			
Store Email Address			

Indicate by check mark that your store meets EACH of the following requirements:
☐ If your store is independently owned but falls under the banner of a larger chain, provide the name of the chain. _____
☐ 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 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 WIC benefits for medical formulas that are excluded from this exemption.

- **Failure to meet ALL of the above requirements will result in denial of your store's request to redeem 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 I agree to terms as described.	
Name (print):	Title:
Signature:	Date: ____ / _____ / _____

Email completed appliction to: Vendor.Applications@health.ny.gov