



STATE OF MISSOURI
 DEPARTMENT OF HEALTH AND SENIOR SERVICES WIC AND NUTRITION SERVICES
WIC SIGNATURE PAD BACKUP FORM

HOUSEHOLD ID NUMBER	
HOUSEHOLD ID NUMBER	TODAY'S DATE

eWIC CARD	
CARD NUMBER	DATE CARD ISSUED

I am: <input type="checkbox"/> Primary Cardholder <input type="checkbox"/> Authorized Representative <input type="checkbox"/> Alternate Representative/Proxy	<input type="checkbox"/> I have received the eWIC card(s) indicated above.
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NAME (PRINT)	SIGNATURE	STAFF INITIALS
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PARTICIPANT'S RIGHTS AND RESPONSIBILITIES

I am: <input type="checkbox"/> Authorized Representative <input type="checkbox"/> Alternate Representative/Proxy	<input type="checkbox"/> I have read and understand my rights and responsibilities under the WIC program. I certify the information and documentation I provided for my household is correct.
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NAME (PRINT)	SIGNATURE	STAFF INITIALS
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BREAST PUMP LOAN/RELEASE

<input type="checkbox"/> I have read and signed the loan/release agreement.	PARTICIPANT NAME
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NAME OF PERSON RECEIVING THE BREAST PUMP (PRINT)	SIGNATURE	STAFF INITIALS
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