

# Illinois WIC Clinic Information Sheet

Date:

**Administrating Agency / Main Site:**

IWIC Agency Number:

WIC Coordinator:

Address:

City:

Zip Code:

Phone:

Fax:

Email:

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**Clinic Site:**

IWIC Clinic Number:

Current Address:

City:

Zip Code:

Phone:

Fax:

Email:

Type of Change:

NEW

CLOSING

ADDRESS  
CHANGE

HOURS / DAYS

New Address or N/A if not applicable:

City:

Zip Code:

Phone:

Fax:

Email:

First date of service at new address:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open:						
Close:						