Notice of Proxy
Section I

(To be completed by the Participant/Parent/Guardian)

I, _____ give my permission for: _____
(Name of Participant/Parent/ Guardian) (Name of Designated Proxy)

To attend certification, recertification, nutrition education, midpoint wellness check, and follow-up appointments on my behalf or on the behalf of my child(ren).

I certify **by initialing each line** that:

_____I understand I am responsible for any designated proxy that I authorize.

_____I understand my designated proxy does not need to have access to my eWIC Card or PIN, in order to represent me or my dependents during WIC visits (recertification, nutrition education, midpoint wellness checks, and follow-up appointments).

_____I understand the WIC Program will not reissue any benefits that are lost, stolen, or misplaced by my designated proxy.

_____I understand I can cancel a Notice of Proxy at any time.

_____I understand in the event I would like to cancel my Notice of Proxy, I **MUST** notify the clinic.

_____I understand this Notice of Proxy is effective for one year.

Designated Proxy for:

Participant's Name	Participant's Date of Birth

Signature of Participant/Parent/Guardian **Date**

This institution is an equal opportunity provider.

Notice of Proxy

Section II

(To be completed by the Designated Proxy)

I certify by initialing each line that:

_____ I understand making a false or misleading statement, misrepresenting, concealing, or withholding facts may result in me repaying the State of Oklahoma, in cash, the value of the food benefits improperly issued to me or the person I am representing and may subject me to civil or criminal prosecution under state and federal law.

_____I understand it is my responsibility as designated proxy to ensure the participant(s) listed on the previous page, receive the WIC benefits and WIC nutrition information.

_____I understand, as designated proxy, that the eWIC Card and/or WIC benefits belong to the person I am representing.

Print Designated Proxy's Name | Telephone Number

Address | Apt. Number

City | State | Zip Code

Designated Proxy's Signature | **Date Signed by Proxy**

	For Office Use Only: **Proxy Expiration Date**
Clinic Staff Signature **Date**	**(1 year from date returned to clinic)**