Florida Department of Health WIC Program

Bloodwork Request Form

Client's Name:_____ **Date of Birth:**_____

WIC ID Number (optional):_____

The following information is needed to complete the client's WIC certification:

Hemoglobin Level:_____ **Date Taken:**_____
OR
Hematocrit Level:_____ **Date Taken:**_____

_____ _____
Signature/Title of Health Professional **Date of Signature**

Office Stamp:

DH 3181, 1/16 *This institution is an equal opportunity provider.*

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