WIC System Access Request

Last Name: _____ First Name: _____ Middle Name: _____

DOB: _____ C/P #: _____ Phone Number: _____ Email Address: _____

All Fields Must Be Completed

Submit completed form to MontanaWICProgram@mt.gov

Additional Access:

Employee Role (Aid, CPA, Etc.): _____ New Position: □ No □ Yes

□ SIS □ SOAR □ SWeb □ Tableau □ Teletask □ Time Study □ WICSmart

□ Healthy Together □ Other: _____

At the Following Locations:

_____ _____

_____ _____

_____ _____

Access Termination to be Completed by Supervisor:

Date of Termination: _____ Reason for Termination: _____

Remove all access: □ Yes □ No Employee transferring to another HHS position: □ Yes □ No

Complete the following when only removing some access:

Access to be removed:
Employee Role: _____

□ SIS □ SOAR □ SWeb □ Tableau □ Teletask □ Time Study □ WICSmart

□ Healthy Together □ Other: _____

At the Following Locations:

_____ _____

_____ _____

_____ _____

State Office Use Only:

Reason for Additional Access: _____

State Nutritionist Signature: _____ Date: _____