

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

Requires Access to:

<input type="checkbox"/> State E-Mail Address	<input type="checkbox"/> SWeb	<input type="checkbox"/> Teletask	<input type="checkbox"/> WICSmart	<input type="checkbox"/> SIS	<input type="checkbox"/> SOAR	<input type="checkbox"/> Tableau
<input type="checkbox"/> Time Study	<input type="checkbox"/> FOB	<input type="checkbox"/> Other: _____				

Role Request:

Clinic:
<input type="checkbox"/> Aide* <input type="checkbox"/> High Risk RN* <input type="checkbox"/> RD* <input type="checkbox"/> CPA* <input type="checkbox"/> Breastfeeding Peer Counselor* <input type="checkbox"/> FMNP Benefits Issuer*
<input type="checkbox"/> LARC <input type="checkbox"/> WIC Director <input type="checkbox"/> Breastfeeding Coordinator
*Documentation of education/training must be provided to the State Office before these roles can be assigned.

State Office:
<input type="checkbox"/> Epidemiologist <input type="checkbox"/> Finance <input type="checkbox"/> Nutrition <input type="checkbox"/> State View <input type="checkbox"/> Vendor Admin <input type="checkbox"/> IT

At the Following Agencies:
<input type="checkbox"/> Beaverhead <input type="checkbox"/> CSKT <input type="checkbox"/> Fort Peck <input type="checkbox"/> Missoula <input type="checkbox"/> Rocky Boy
<input type="checkbox"/> Big Horn <input type="checkbox"/> Custer One Health <input type="checkbox"/> Gallatin <input type="checkbox"/> Northern Cheyenne <input type="checkbox"/> Sanders
<input type="checkbox"/> Blackfeet <input type="checkbox"/> Dawson <input type="checkbox"/> Glacier <input type="checkbox"/> Park <input type="checkbox"/> Silver Bow
<input type="checkbox"/> Carter <input type="checkbox"/> Deer Lodge <input type="checkbox"/> Hill <input type="checkbox"/> Pondera <input type="checkbox"/> Teton
<input type="checkbox"/> Cascade <input type="checkbox"/> Fergus <input type="checkbox"/> Lake <input type="checkbox"/> Ravalli <input type="checkbox"/> Toole
<input type="checkbox"/> Chouteau <input type="checkbox"/> Flathead <input type="checkbox"/> Lewis and Clark <input type="checkbox"/> Richland <input type="checkbox"/> Valley
<input type="checkbox"/> Crow <input type="checkbox"/> Fort Belknap <input type="checkbox"/> Lincoln <input type="checkbox"/> Riverstone
<input type="checkbox"/> Other: _____

State Office Use Only:

Access Requested Above: <input type="checkbox"/> Approved <input type="checkbox"/> Denied Reason: _____
State Nutritionist Signature: _____ Date: _____

IT Notes Only:

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