CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR
WOMEN, INFANTS AND CHILDREN PROGRAM (WIC)
LOCAL AGENCY CIVIL RIGHTS COMPLAINT LOG
FY24

Local Agency Name:_____ Site:_____

DATE COMPLAINT RECEIVED	**CLAIMANT NAME, PHONE #, EMAIL**	**NATURE OF COMPLAINT** (Include name(s) of WHO committed the discriminatory act, including witnesses, WHERE and WHEN the act was committed)	**DATE SENT TO DPH**	**COMMENT(S)**