West Virginia University Institute for Community and Rural Health
Dental Service Program
Certification of Educational Status

Applicant:

Please complete the section below and give it to an official in your Dean's Office who must complete and directly return it to the Institute for Community and Rural Health, PO Box 9009, Morgantown WV 26506-9009 by the deadline (**December 13, 2024**).

Name: ______________________ ____________________ _____________________
(Last) (First) (Middle)

________________________ _____________________ WV __________
(Address) (City) (State) (Zip Code)

Evening/Home Phone: ______________________________ Cell Phone: ___________________________________

E-mail: ____

I, the undersigned, do hereby authorize documentation of my educational status to the WVU Institute for Community and Rural Health.

Signed: ____ Date: ____________________________

School Official

Please provide the information requested and return this form directly to the Institute for Community and Rural Health Service Program Committee by the deadline (**December 13, 2024).**

The above-named student is currently enrolled and is in good academic and professional standing at West Virginia University School of Dentistry.

____
(Expected Graduation Date)

Comments:

Signed:

____
(Official or Program Director)

____
(Title)