

**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 12, 2025**).

Name: \_\_\_\_\_  
(Last) (First) (Middle)

\_\_\_\_\_  
(Address) (City) WV (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 12, 2025**).

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:

(Affix Seal)

Signed:

\_\_\_\_\_  
(Official or Program Director)

\_\_\_\_\_  
(Title)