

**West Virginia Physician Assistant Rural Health Scholarship Program
Certification of Educational Status**

Applicant:

Please complete the section below and give it to an official in your Program Director'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 11, 2026**).

Name: _____
(Last) (First) (Middle)

(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: _____

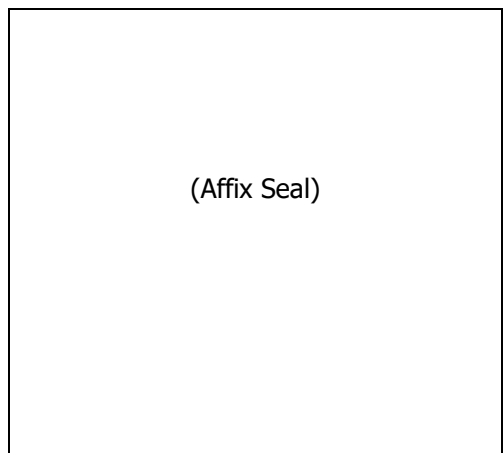
School Official

Please provide the information requested and return this form directly to the Institute for Community and Rural Health Scholarship Committee by the deadline (**December 11, 2026**).

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

(Expected Graduation Date)

Comments:



Signed:

(Official or Program Director)

(Title)