



Virginia Department of
Health Professions
Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)
bodlicensing@dhp.virginia.gov
<https://www.dhp.virginia.gov/Boards/Dentistry/>

FORM A
CERTIFICATION OF DENTAL SCHOOL
Post-Doctoral Specialty Programs ONLY

Applicant: Enter **only** your name and graduation date below, and then send this form to the Dean or Director of each Dental School or Program, which granted you a degree or certificate.

APPLICANT _____ **GRADUATION DATE:** _____

DEAN/PROGRAM DIRECTOR: Please provide certification that the applicant named above received a dental degree or certificate from your program and certification that the program completed was accredited by the Commission on Dental Accreditation of the ADA (CODA) or the Commission on Dental Accreditation of Canada (CDAC) at the time the applicant completed the program. The certification may be provided by completing this form or by providing an official detail letter with all the information requested on this form. Either document must bear the school's seal.

Certifications made prior to the applicant's graduation cannot be accepted.

NAME OF SCHOOL: _____

NAME OF PROGRAM: _____

PROGRAM'S CODA/CDAC ACCREDITATION STATUS ON THE DATE THE DEGREE OR CERTIFICATION WAS GRANTED:

- | | | |
|-------|-------------------------------------------|-----|
| A1: | Approval (without reporting requirements) | [] |
| A2: | Approval (with reporting requirements) | [] |
| IA: | Initial accreditation | [] |
| DIS: | Accreditation voluntarily discontinued | [] |
| WDRN: | Accreditation withdrawn | [] |
| X: | Intent to withdraw accreditation | [] |
| T: | Program is in Teach-Out by institution | [] |
| NE: | Required period of non-enrollment | [] |

DEGREE or CERTIFICATION GRANTED: _____

DATE DEGREE or CERTIFICATION GRANTED: _____ / _____ / _____
Month Day Year

By affixing my signature below, I certify that the applicant named above is a graduate and a holder of a diploma or a certificate from a CODA/CDAC accredited dental program.

SEAL

Signature

Print Name

Title

Date

DEAN/REGISTRAR: Please provide the applicant an original final transcript of this alumni record, to include courses, grades, degree, or certificate received, and date the degree or certificate was conferred, which bears the certified signature of the registrar and has the college seal affixed.