CONTINUING EDUCATION CERTIFICATE FOR DONATED SERVICES

Dentist name:_____ Male_____ Female_____

Address:_____
(Street or PO Box)

_____
(City) (State) (Zip)

Telephone:_____

WV License No._____

Dentist's Signature:_____

The above dentist contributed _____ hours of dental care and services to _____ patient(s) during the following dates:_____

Types of services/treatment:_____

_____

Services/treatment documented by:_____
(Name of charity clinic or other facility)

Address:_____
(Street or PO Box)

_____
(City) (State) (Zip)

Telephone:_____

Signed by:_____
(Print name)

Signature:_____Date:_____