West Virginia Board of Dentistry
PO Box 1447, Crab Orchard, WV 25827
(304) 252-8266

Low Income Waiver of Initial Licensing Fee

Applicant's Name:_____ Date of Birth:_____

Address:_____
Street City State Zip

Please select one of the following criteria.

☐ **I attest that my annual household income, before taxes, is below 130% of the federal poverty line.** (Please visit https://aspe.hhs.gov/poverty-guidelines for more information on federal poverty line.)

Annual Household Income:_____
Please attach a copy of your most recent tax forms (W-2, 1099, etc.) to this application.

OR

☐ **I am enrolled in a state or federal public assistance program**.
Please attach a copy of your program acceptance letter to this application.

☐ SNAP
☐ TANFP
☐ Medicaid
☐ Other_____

Affirmation by Written Declaration

I understand that I am to personally complete this waiver, and am solely responsible for the accuracy and completeness of the information provided. I have carefully read and understood all instructions in the form. By signing this wavier, I certify that the information provided in connection therewith is complete, true, and correct to the best of my knowledge and belief. I understand that any determination of waiving the initial licensure fee if based on the truth and accuracy of the information provided herewith. I further understand that the information provided herewith is subject to investigation and verification by the WV Board of Dentistry.

_____
Applicant's Signature Date