



**2007 – 2008  
DEPENDENT STUDENT  
MEDICAL & DENTAL VERIFICATION**

Please itemize your paid medical and dental expenses not reimbursed by insurance in the amount of \$ \_\_\_\_\_ below. Attach additional pages if necessary.

2006 or 2007 (please do not use expenses from both years)

<u>DATE PAID</u>	<u>TO WHOM PAID</u>	<u>AMOUNT PAID</u>
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We certify that we have paid the above amount of medical and dental expenses including premiums paid. We certify that none of the above expenses was reimbursed by insurance. We certify that this information is correct to the best of our knowledge. We will provide paid receipts or cancelled checks, if necessary.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

1401 College Avenue, Box B  
Levelland, TX 79336  
Ph: (806) 894-9611 ext. 3800  
Fax: (806) 894-8653

STUDENT SSN \_\_\_\_\_

(Your social security number is being requested because it is a unique identification number that is maintained for the purpose of verifying that the correct student record is being updated, for tracking purposes and for state and federal report requirements.)