Navy Armed Forces Health Professions Scholarship Program – Dean's Certification of Reimbursable Items

Student Name	LAST 4 digits of your Social Security Number	University
Year Level	**Graduation Date**	**Course of Study [Medical - Dental - Optometry]**

I have reviewed the attached claim for reimbursement (OF-1164) in the amount of **$_____,** submitted by the above named student. I certify purchases contained therein are consistent with those incurred by all students in this course of study and year level, whether in the Navy's Armed Forces Health Professions Scholarship Program or not. I have lined through to DISALLOW any item not REQUIRED by all students. I have made pen-and-ink adjustments to the item quantity to show only quantity required, if necessary.

HEALTH INSURANCE (Fill in 1 if applicable, and **initial 1, 2 or 3** below)

1) Is required and payable directly by the student, not billed on a separate tuition invoice. The rate of coverage for a single (no spouse or dependants) school-provided plan is **$_____** for the coverage period (enter dates) **____/____/____ to ____/____/____** inclusive. **Initial HERE** _____

2) Is required but there is no school-provided plan. **Initial HERE** _____

3) Is NOT required or NOT claimed on attached SF-1164. **Initial HERE** _____

DENTAL / VISION INSURANCE (Fill in 1 if applicable, and **initial 1, 2 or 3** below)

1) Is required and payable directly by the student, not billed on a separate tuition invoice. The rate of coverage for a single (no spouse or dependants) school-provided plan is **$_____** for the coverage period (enter dates) **____/____/____ to ____/____/____** inclusive. **Initial HERE** _____

2) Is required but there is no school-provided plan. **Initial HERE** _____

3) Is NOT required or NOT claimed on attached SF-1164. **Initial HERE** _____

By my signature below I certify that, to the best of my knowledge and belief, the items listed are required as outlined above, and no item claimed was or will be billed on a separate tuition invoice.

Must be signed by the Dean, Residency Program Director or an authorized representative.

Signature of School Official reviewing claim _____

Print or type name _____ **Date** _____/_____/_____

Title _____ **Phone Number (**_____**)** _____-_____