###### **ADMINISTRATOR VERIFICATION FOR ALL REPORT SUBMISSIONS**

**Discipline Name**

**Type of Report: Enter Type of Report (progress, response to site visit, program change, etc.)**

**Date of Submission: Enter Actual Date of Submission of Report**

**I have reviewed this document and verify that the information in it is accurate and complete, and that it complies with the *Commission on Dental Accreditation’s Privacy and Data Security Requirements for Institutions* found at** [**https://coda.ada.org/policies-and-guidelines/hipaa-compliance**](https://coda.ada.org/policies-and-guidelines/hipaa-compliance) **(the “Requirements”) and that this document contains no prohibited Sensitive Personal Information (SPI) or Protected Health Information (PHI) as defined in the Requirements, and that the individual(s) signing and/or submitting this verification has the authority to sign and submit on behalf of the sponsoring institution, themselves, and the other individuals listed below.**

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| **SPONSORING INSTITUTION *(If the program is co-sponsored, a verification page from each sponsor must be submitted)*** |
| **Institution Name:**  Street Address  (do not list P.O. Boxes)  City, State, Zip |
| **Chief Executive Officer**  (Univ. Pres, Chancellor, Hospital President)  Name:  Title:  Phone:  E-Mail:  Signature:  Date: |
| **Chief Administrative Officer**  (Dental Dean/Chair/Chief of Dental Service)  Name:  Title:  Phone:  E-Mail:  Signature:  Date: |
| **Program Director**  Name:  Title:  Phone:  E-Mail:  Signature:  Date: |