OFFICE OF FINANCIAL AID
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OFFICE OF FINANCIAL AID
COLORADO STATE UNIVERSITY

Conditional Discharge
Certification from Physician and Borrower

We have received the information you submitted on the Free Application for Federal Student Aid (FAFSA). Based on information from the National Student Loan Data System, you previously received loans that have been conditionally discharged based on an initial determination of total and permanent disability. A hold has been placed on the processing of your FAFSA until the following certification statements are completed and submitted to Student Financial Services.

BORROWER'S CERTIFICATION

I acknowledge that any additional loans that are received cannot be discharged in the future on the basis of any impairment present when the new loan is made, unless that impairment substantially deteriorates pursuant to CFR 685.200(a)(iv)(A)(2).

I acknowledge that the loan that has been conditionally discharged prior to a final determination of total and permanent disability cannot be discharged in the future on the basis of any impairment present when I applied for the disability discharge or when the new loan is made, unless that impairment substantially deteriorates pursuant to CFR 685.200(a)(iv)(B)(3).

I acknowledge that the suspension of collection activity on the prior loan will be lifted pursuant to CFR 685.200(a)(iv)(B)(4). In addition, collection activity must begin before I may receive a new loan pursuant to CFR 685.200(a)(iv)(B)(1).

_____ _____
Borrower's Signature Date

_____
Borrower's Name (please print or type)

_____
Borrower's CSUID

(over)

PHYSICIAN'S CERTIFICATION

Under the Federal Direct Loan Program administered by the United States Department of Education, a borrower is entitled to receive additional Federal Direct Loans after a period of total and permanent disability only if a qualified physician can certify the borrower's ability to engage in substantially gainful activity pursuant to CFR 685.200(a)(iv)(A)(1).

Have your physician complete the following:

I certify that, in my best professional judgment, my patient _____ is now able to engage in substantially gainful activity.

I am legally authorized to practice medicine/osteopathy in the State of _____. I declare under penalty of perjury under the laws of the United States of America that the aforementioned is true and correct.

_____ _____
Signature of Physician (M.D. or D.O.) Date

_____
Physician's Name (please print or type)

_____
Physician's Street Address

_____
Physician's City/State

_____
Physician's Telephone Number