Total and Permanent Disability 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 were discharged due to 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 the Office of Financial Aid.

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).

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