



The Financial Aid Office has been notified that you previously had a Federal Stafford Loan or Federal Direct Loan that was discharged due to total and permanent disability.

In order to receive future Federal Stafford Loans, federal regulations stipulate that you must:

- Provide physician's certification that the student is able to attend school without hindrance from their disability.
- Student must sign acknowledging that loan can not be cancelled in the future based on impairment.

|  |       |          |                          |
|--|-------|----------|--------------------------|
| Last Name                                    | First | Middle   | Social Security Number   |
| Permanent address (Include apartment number) |       |          | Email Address            |
| City   | State | Zip Code | (area code) Phone Number |

**Student Certification Statement**

**"I understand that all future Federal Stafford Loans that I receive cannot be cancelled in the future based on my present impairment."**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Physician Certification Statement**

Instructions for Physician: You are being asked to complete and sign this form to certify that the aforementioned person whose loan (s) were previously discharged due to a total and permanent disability is presently able to engage in substantial gainful activity because the disabling condition or impairment has substantially improved.

Diagnosis of the aforementioned person's present medical condition:

\_\_\_\_\_

Borrower is: Ambulatory \_\_\_\_\_ Other: \_\_\_\_\_

When did the aforementioned person's illness/injury substantially improve? \_\_\_\_\_ (mm/dd/ccyy)

Prognosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that I am a doctor of medicine or osteopathy and legally authorized to practice and that in my best professional judgment, the person named above is able to engage in substantial gainful activity, i.e., work and earn money.

Physician's Signature/Date: \_\_\_\_\_

Physician's Name (typed/print): \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

State of Professional Registration: \_\_\_\_\_

Professional Registration Number: \_\_\_\_\_