# 2015-2016 Verify Loan Disability Discharge Form

*Eligibility Reinstatement Form for Federal Student Loan Programs after a Previous Total and Permanent Disability Discharge*

This form serves to reestablish your eligibility for Federal Student Loan Programs when prior loans have been discharged due to total and permanent disability. Completion of this form does not guarantee that you will qualify for the Federal Student Loan Programs.

## STUDENT SECTION

<table>
<thead>
<tr>
<th>Name (please print):</th>
<th>Date of Birth:</th>
<th>Student ID Number:</th>
</tr>
</thead>
</table>

Social Security Number: XXX-XX-_________ Telephone:______________________________

## COMPLETE IF YOU DO NOT INTEND TO PURSUE YOUR FEDERAL LOAN ELIGIBILITY

- No, I am not interested in receiving Federal Loans
- I am not interested in receiving loans, but am interested in grants and/or Federal Work Study.

Student Signature ___________________________ Date _____________________________

## COMPLETE IF YOU WISH TO PURSUE YOUR FEDERAL LOAN ELIGIBILITY

- Yes, I am interested in receiving Federal loans and have a Physician Certification on file from a prior year.
- Yes, I am interested in receiving Federal loans and will be submitting my Physician Certification to verify my eligibility.

I acknowledge that I have previously received a total and permanent disability discharge either through the Federal Family Education Loan Program, William D. Ford Federal Direct Loan Program, or Federal Perkins Loan Program. By my signature below, I clearly understand that any additional student loans I receive must be repaid in full and cannot be canceled in the future on the basis of any impairment present when the new loan is made unless that impairment substantially deteriorates as determined by my physician.

CONSENT FOR RELEASE OF INFORMATION: I authorize any physician, hospital, or other institution having records pertaining to the disability for which I previously received cancellation of my loan(s) to make information from such records available to the Financial Aid Office, the U.S. Department of Education, or to the holder of my loan(s).

Student’s Signature ___________________________ Date _____________________________

Form ID: F16LDV
Physician Certification

Physician certification required for Federal Student Loan Programs after a Previous Total and Permanent Disability Discharge.

PHYSICIAN SECTION

The referenced student, ______________________________, was previously classified as totally and permanently disabled and as a result of this condition received a total discharge of his/her federal student loan indebtedness. The borrower is now requesting financial aid from one of the Federal education loan programs. The U.S. Department of Education requires that a physician certify that a borrower is once again able to engage in substantial gainful activity, i.e., the person is sufficiently recovered to be capable of attending school, successfully completing a program of study, and securing employment in order to repay the loan he/she is seeking. Your completion of this section will fulfill this requirement.

PHYSICIAN SECTION

I certify in my best professional judgment that the above named student is able to engage in substantial gainful activity as defined by the U.S. Department of Education.

Warning: Previous student loan debts have been cancelled due to Total and Permanent Disability. Certification of this form enables the borrower to obtain additional student loans. Any person who knowingly makes a false statement or misrepresentation on this form shall be subject to penalties which may include fines or imprisonment under the United States Criminal Code and 20USC1097.

___________________________________________________
Physician Name:___________________________________________________
Address of Practice:_________________________________________________
City, State, Zip Code:_______________________________________________
Office Phone Number:_______________________________________________

COMPLETE IF CONFIRMING STUDENT’S GAINFUL ACTIVITY

I certify that, in my best professional judgment, the condition of the student named above has not improved enough to allow him or her to engage in substantial gainful activity

____________________________________________________
Physician Signature
Date

COMPLETE IF CONDITION HAS NOT IMPROVED

I certify that, in my best professional judgment, the condition of the student named above has not improved enough to allow him or her to engage in substantial gainful activity

____________________________________________________
Physician Signature
Date

PHYSICIAN CONTACT INFORMATION

Please Type or print the following:

Physician Name:___________________________________________________
Address of Practice:_________________________________________________
City, State, Zip Code:_______________________________________________
Office Phone Number:_______________________________________________

Form ID: F16LDV