

Revised: 12/16/20

Office of Student Financial Aid & Scholarships Physician's Certification and Borrower's Acknowledgement of Obligation

OFFICE USE ONLY

Student Name: _____ NSHE ID: _____

General Information: The purpose of this form is to have a licensed physician certify that the student borrower is able to engage in substantial gainful activity and to have the borrower acknowledge that any federal loans received as a result of this physician's certification cannot be canceled based on any present impairment or condition, unless that impairment or condition substantially deteriorates to the extent that the definition of total and permanent disability is met. This form will allow the borrower to secure additional loans under one or more of the following Federal Loan Programs: Federal Direct Student Loans, Parent PLUS Loans, and Consolidation Loans.

Definition of Total and Permanent Disability: To be totally and permanently disabled, the borrower must be unable to work and earn money or attend school because of an injury or illness that is expected to continue indefinitely or result in death. This definition calls for a judgment decision as to the borrower's ability to earn income despite the borrower's disability. The physician is to assess the impact of the borrower's disability on their ability to earn income in light of what the borrower would normally be able to earn if they were not disabled. If the disability appears to have a significant adverse effect on the borrower's earning potential, not only in the type of work performed before the impairment but for any substantial gainful employment, and the disability is expected to last for a long and indefinite period of time, then the borrower shall be considered permanently disabled under this definition. If, however, the borrower's condition has improved so that the borrower is able to engage in substantial gainful activity or attend an institution of post-secondary education, a reaffirmation (reinstatement, no longer in discharge status) can be processed to allow the borrower to complete procedures for eligibility for Title IV (federal) student aid. Receipt of this completed form with the appropriate physician's certification satisfies the federal requirements [34 CFR 682.201(a)(5)] for affected borrowers.

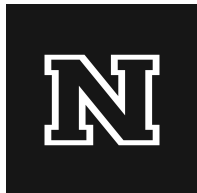
Warning: If you receive student aid based on incorrect information, you may have to return it and/or pay fines and fees. Providing false or misleading information on this form may result in a fine of \$20,000 and/or a prison sentence.

SECTION 1: STUDENT CERTIFICATION

Indicate whether you would like to be considered for Federal Student Loans by checking the appropriate box(es) below.

| | |
|--------------------------|---|
| <input type="checkbox"/> | No, I do not wish to be considered for Federal Student Loans; I only want to apply for the Pell Grant. If you select this option, sign and date below, then return this page to the Financial Aid Office. |
| <input type="checkbox"/> | Yes, I want to be considered for Federal Student Loans. If you select this option, acknowledge the following by checking the boxes below, then return both pages to the Financial Aid Office after obtaining certification from your physician (only a Doctor of Medicine or a Doctor of Osteopathy who is legally authorized to practice in your state may complete this form). |
| <input type="checkbox"/> | I am aware that the new Federal Student Loan cannot later be discharged for any present impairment unless it deteriorates so that I am again permanently disabled. |
| <input type="checkbox"/> | I am aware that collection activity will resume on any loans in a conditional discharge period. |
| <input type="checkbox"/> | If I am attempting to obtain new loans within the three-year conditional discharge period, I acknowledge that the suspension of collection activity on the conditionally discharged loan will be lifted. |
| <input type="checkbox"/> | The suspension of collection activity on the conditionally discharged loan must be lifted before I, the borrower, can receive the new loan. (This means that the loan is no longer conditionally discharged and I am responsible for repaying it.) |
| <input type="checkbox"/> | Unless my condition substantially deteriorates, the old loan cannot be discharged in the future for any impairment present when I began the conditional discharge or when I tried to get the new loan. |
| <input type="checkbox"/> | I understand that the Physician's Certification (section 2) states that I have the ability to engage in substantial gainful activity, and that I am sufficiently physically recovered from my previous condition, such that I am capable of attending school, successfully completing a program of study, and securing employment in order to repay the new loan(s) I am seeking. |

Student Signature: _____ Date: _____



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Privacy Act Notice: The Privacy Act of 1974 (5 U.S.C 522a) requires that an agency provide the following notice to each individual whom it asks to supply information.

- The authority for collecting the information requested on this form is found in 20 U.S.C. 1087, 42 U.S.C. 209 4k and 22 U.S.C. 2601.
- The principal purpose of this information is to verify the identity of the borrower; determine that the borrower is able to engage in substantial gainful activity; and in the event it is necessary, to locate the borrower's certifying physician.
- The routine uses of this information include its disclosure to Federal, State, or local agencies, to guaranty agencies, to education and financial institutions, and to agency contractors for the purpose of verifying the identity of the borrower and the borrower's physician; determining that the borrower is able to engage in substantial gainful activity; investigating possible fraud; and verifying compliance with program regulations. Failure to provide the requested information may result in denial of the borrower's new loan request.
- This information is necessary to process requests for new Federal Loan Programs.

SECTION 2: PHYSICIAN'S CERTIFICATION
(to be completed by certifying physician only)

Physician Name: _____

Physician's License Number: _____

I am legally authorized to practice in the state of: _____

Address (street number, city, state, zip code): _____

Phone Number: _____

Patient/Borrower Name: _____

Select one of the following:

In my professional medical judgment of the patient/borrower named above, and in accordance with the purposes of this form and the definition of a Total and Permanent Disability (see first page), I certify that the patient/borrower is able to engage in substantial gainful activity and can attend school.
 Date borrower became able to work and earn wages: _____

In my professional medical judgment of the patient/borrower named above, and in accordance with the purposes of this form and the definition of a Total and Permanent Disability (see first page), I CANNOT certify that the patient/borrower is able to engage in substantial gainful activity and attend school.

Physician's Signature: _____ **Date:** _____