

## PHYSICIAN'S CERTIFICATION OF BORROWER'S TOTAL AND PERMANENT DISABILITY

**PRA Burden Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1845-0124. Public reporting burden for this collection of information is estimated to average 5 minutes for the borrower, 10 minutes for the holder/servicer, and 30 minutes for the physician per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain benefit (the Consolidated Appropriations Act, 2014). If you have comment or concerns regarding the status of your individual submission of this form, please contact the HEAL Program, U.S. Department of Education, 830 First Street NE, Washington, DC 20202 directly. [Note: Please do not return the completed form to this address.]

**WARNING: ANY PERSON WHO KNOWINGLY MAKES A FALSE STATEMENT OR MISREPRESENTATION ON THIS FORM MAY BE SUBJECT TO FINE OR IMPRISONMENT UNDER SECTION 1001 OF THE UNITED STATES CRIMINAL CODE.**

### GENERAL INSTRUCTIONS

This form is used for obtaining a physician's certification of a borrower's permanent and total disability for the purpose of cancellation of the borrower's obligation to repay his or her student loan(s) obtained under the Health Education Assistance Loan (HEAL) program.

**DEFINITION OF TOTAL AND PERMANENT DISABILITY** - Physician must certify that the borrower is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that (1) can be expected to result in death; (2) has lasted for a continuous period of at least 60 months; or (3) can be expected to last for a continuous period of at least 60 months. Substantial gainful activity means a level of work performed for pay or profit that involves doing significant physical or mental activities or a combination of both. If the borrower is able to engage in any substantial gainful activity in any field of work, physician must not certify total and permanent disability.

It should be noted that the standard for determining disability for cancellation of the borrower's loan obligation may be different from standards used under other public and private programs in connection with occupational disability or eligibility for social service benefits.

#### INSTRUCTIONS FOR BORROWER

- Complete Section I and sign the form. A representative of the borrower may complete this section and sign the form on the borrower's behalf if the borrower is unable to do this because of his or her disability.
- Have Section II of the form completed and signed by a doctor of medicine or doctor of osteopathy.
- Return a completed copy(s) of this form to each holder/servicer which has made a loan to you under the Health Education Assistance Loan (HEAL) program.

**Before sending to your loan holder/servicer, please, make sure that Section II (Certification of Borrower's Total and Permanent Disability) has been completed. If you are a disabled Veteran, please contact your servicer prior to submission.**

#### INSTRUCTIONS FOR PHYSICIAN

**PLEASE NOTE:** Complete this form only if you are a doctor of medicine or a doctor of osteopathy legally authorized to practice in your state

- Complete Section II and sign the certification only if the borrower's condition meets the above definition of total and permanent disability. Please make your report complete, as to the nature, duration and severity of the borrower's present and future impairment. You may attach additional pages if necessary.
- Return this form to the borrower listed in Section I.**

### Section I – TO BE COMPLETED BY BORROWER OR BORROWER'S REPRESENTATIVE (See instructions above. See Privacy Act notice on reverse side.)

1. NAME OF BORROWER (Last) (First) (MI)	2. BORROWER'S SOCIAL SECURITY NUMBER
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3. NAME AND ADDRESS OF BORROWER OR BORROWER'S REPRESENTATIVE (Print or type)	4. AGE OF BORROWER
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5. DATE OF BIRTH	MM	DD	YYYY
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6. DATE ENTERED HEAL SCHOOL	7. GRADUATION DATE	8. COURSE OF STUDY
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MM DD YYYY

MM DD YYYY

9. EMPLOYMENT HISTORY (since separation from school)

**CONSENT FOR RELEASE OF INFORMATION** – I authorize any physician, hospital or other institution having records pertaining to the disability for which I am requesting discharge of my loan(s) to make information from such records available to the Department of Education and to the holder/servicer of my loan(s). I authorize the Department of Education to contact my physician(s) to receive my medical records and discuss my medical condition.

SIGNATURE OF BORROWER OR REPRESENTATIVE

DATE

MM DD YYYY

See Back for Sections II and III

## SECTION II – TO BE COMPLETED BY CERTIFYING PHYSICIAN

1. WHEN DID THE BORROWER'S PRESENT ILLNESS OR INJURY START?  <div style="text-align: center;">           MM      DD      YY            ____/____/____         </div>	2. WHEN DID THE BORROWER BECOME UNABLE TO ENGAGE IN ANY SUBSTANTIAL GAINFUL ACTIVITY?  <div style="text-align: center;">           MM      DD      YY            ____/____/____         </div>
3. DIAGNOSIS OF BORROWER'S PRESENT MEDICAL CONDITION.  <hr/> <hr/> <hr/> <hr/>	
4. NATURE OF ONSET  <hr/> <hr/> <hr/> <hr/>	
5. CURRENT MEDICATIONS  <hr/> <hr/> <hr/> <hr/>	
6. REHABILITATION PLANS (Include any treatment which has not been accepted by the Borrower)  <hr/> <hr/> <hr/> <hr/>	
7. BORROWER IS <input type="checkbox"/> AMBULATORY; <input type="checkbox"/> BED CONFINED; <input type="checkbox"/> HOUSE CONFINED; <input type="checkbox"/> HOSPITAL CONFINED; <input type="checkbox"/> OTHER _____	
8. PROGNOSIS – IS THE APPLICANT'S IMPAIRMENT EXPECTED TO RESULT IN DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", SKIP TO ITEM 9. IF "NO" CONTINUE TO ITEM 8A. 8A. - HAS THE APPLICANT'S IMPAIRMENT LASTED OR IS IT EXPECTED TO LAST FOR A CONTINUOUS PERIOD OF AT LEAST 60 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", CONTINUE TO ITEM 9. IF "NO" DO NOT COMPLETE THIS APPLICATION.	

### 9. PHYSICIAN CERTIFICATION OF BORROWER'S TOTAL AND PERMANENT DISABILITY

I certify that in my best professional judgment (borrower's name \_\_\_\_\_) is unable to engage in any substantial gainful activity by reason of any medically-determinable physical or mental impairment that can be expected to result in death; has lasted for a continuous period of not less than 60 months; or that can be expected to last for a continuous period of not less than 60 months.

I am legally authorized to practice in the State of \_\_\_\_\_. Professional License No. \_\_\_\_\_

10. NAME & ADDRESS OF PHYSICIAN ( <i>Print or type</i> )   	11. DATE <div style="text-align: center;">           MM      DD      YY            ____/____/____         </div> 12. SIGNATURE OF PHYSICIAN (M.D. OR D.O.)  
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## SECTION III – TO BE COMPLETED BY LOAN HOLDER/SERVICER (Borrower and Physician leave blank)

1. LOAN HOLDER/SERVICER NAME  	2. LOAN HOLDER/SERVICER ADDRESS  
3. TOTAL AMOUNT OF UNPAID BALANCE  \$ _____	4. DATE PREPARED BY HOLDER/SERVICER <div style="text-align: center;">           MM      DD      YYYY            ____/____/____         </div>

**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.

1. The authority for collecting the information requested on this form is found in 34 CFR 681.39 (b) and 685.213 and the Consolidated Appropriations Act, 2014.
2. The principal purposes of this information are to verify the identity of the borrower; eligibility for loan cancellation; and in the event it is necessary to locate the borrower's representative or certifying physician. The SSN is used as a loan account number (identifier) in order to accurately record necessary information.
3. The routine uses of this information include its disclosure to Federal, State or local agencies, to guarantee agencies, to educational and financial institutions and to agency contractors for the purpose of: verifying the identity of the borrower and the borrower's physician; determining the borrower's eligibility for loan cancellation; investigating possible fraud and verifying compliance with program regulations. Failure to provide the requested information may cause the Department of Education to deny the borrower's request for loan cancellation.
4. This information is necessary to process requests for loan cancellation.