

Applicant Name: \_\_\_\_\_ Last 4 of SSN: \_\_\_\_\_

**Section 4: Physician's Certification**

**READ THIS FIRST:** The applicant identified above is applying for a discharge of a private student loan on the basis that he or she has a total and permanent disability. To qualify for a discharge, the applicant must have a total and permanent disability being 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 not less than 60 months; or (3) can be expected to last for a continuous period of not less than 60 months. This disability standard may be different from standards used under other programs in connection with occupational disability or eligibility for social service or veteran's benefits. A determination that the applicant is disabled by a federal agency (for example, the Social Security Administration) or a state agency does not establish the applicant's eligibility for this loan discharge.

**Instructions for Physician:**

- Complete this form only if you are a Doctor of Medicine or Doctor of Osteopathic Medicine legally authorized to practice in the United States and only if the applicant's condition meets the definition of total and permanent disability above.
- Type or print in dark ink. All fields must be completed. If a field is not applicable, enter "N/A." Your signature date must include month, day, and year (mm-dd-yyyy).
- Provide all requested information for Items 1, 2, and 3 below, and attach additional pages if necessary. Complete the physician's certification at bottom of the next page. The applicant's loan discharge application cannot be processed if the information requested in this section is missing.
- If you make any changes to the information you provide in this section, you must initial each change.
- **Please return the completed form to the applicant or the applicant's representative.**

**1. Ability to Engage in Substantial Gainful Activity.** Does the applicant have a medically determinable physical or mental impairment (as explained in Item 2 below) that **(a)** prevents the applicant from engaging in any substantial gainful activity, in any field of work, and **(b)** can be expected to last for a continuous period of not less than 60 months? **Yes No**

**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 applicant is able to engage in any substantial gainful activity, in any field of work, you must answer "No."*

**IF THE ANSWER TO QUESTION 1 IS NO, DO NOT COMPLETE THIS APPLICATION.**

**2. Disabling Condition.** Complete the following regarding the applicant's disabling physical or mental impairment. Do not use abbreviations or insurance codes.

**(a)** Provide the diagnosis: \_\_\_\_\_

**(b)** Describe the severity of the disabling physical or mental impairment, including, if applicable, the phase of the disabling condition: \_\_\_\_\_

**3. Limitations.** Explain how the disabling condition prevents the applicant from engaging in substantial gainful activity in any field of work by responding to Items (a) through (e) below, as relevant to the applicant's condition. Attach additional pages if more space is needed.

In addition to what is required, you may include any additional information that you believe would be helpful in understanding the applicant's condition, such as medications used to treat the condition, surgical and non-surgical treatments for the condition, etc.

(a) Limitations on sitting, standing, walking, or lifting: \_\_\_\_\_

\_\_\_\_\_

(b) Limitations on activities of daily living: \_\_\_\_\_

\_\_\_\_\_

(c) Residual functionality: \_\_\_\_\_

\_\_\_\_\_

(d) Social/behavioral limitations, if any: \_\_\_\_\_

\_\_\_\_\_

(e) Current Global Assessment Function Score (for psychiatric conditions): \_\_\_\_\_

#### Physician's Certification

- I certify that, in my best professional judgment, the applicant identified above is unable to engage in any substantial gainful activity in *any* field of work 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 not less than 60 months, or (3) can be expected to last for a continuous period of not less than 60 months.
- I understand that an applicant who is currently engaged in any substantial gainful activity in *any* field of work does not have a total and permanent disability as defined on this form.

I am a (check one)    Doctor of Medicine    Doctor of Osteopathic Medicine

I am legally authorized to practice in the state of \_\_\_\_\_, and my professional license number is \_\_\_\_\_ (subject to verification through state records).

\_\_\_\_\_  
Physician's Signature (a signature stamp is not acceptable)

\_\_\_\_\_  
Date (mm-dd-yyyy)

\_\_\_\_\_  
Printed Name of Physician (first name, middle initial, last name)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip Code

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Email Address (Optional)