

2025-2026 Total and Permanent Disability Certification Form

Student Information:

Last Name First M.I. W00 _____
Student I.D.

Address City State Zip code Phone Number

According to the U.S. Department of Education, you have had one or more student loans or grants discharged because of total and permanent disability. This form serves to reestablish your eligibility for Federal Student Loan or TEACH Grant Programs when prior loans or a TEACH Grant service obligation 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 or TEACH Grant Programs.

COMPLETE IF YOU DO NOT INTEND TO PURSUE YOUR FEDERAL LOAN OR TEACH GRANT ELIGIBILITY

_____ No, I am not interested in receiving Federal Loans and/or a TEACH Grant
_____ I am not interest in receiving loans, but I am interested in OTHER Federal Grants and/or Federal Work Study.

Student Signature

Date

COMPLETE IF YOU WISH TO PURSUE YOUR FEDERAL LOAN OR TEACH GRANT ELIGIBILITY

_____ Yes, I am interested in receiving Federal loans and/or a TEACH Grant and have a Physician Certification on file dated within one-year of today.

_____ Yes, I am interested in receiving Federal loans and/or a TEACH Grant 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, Federal Perkins Loan Program, or TEACH Grant service obligation. By my signature below, I clearly understand that any additional student loans or TEACH Grant service obligation 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.

I acknowledge that if my prior Total and Permanent Disability discharged loan or TEACH Grant service obligation is within the three-year provisional period (this period is not applicable to Veterans who received TPD discharges based on a qualifying disability determination by the VA) allowed for disability cancellation, I am required to resume payment on that loan or TEACH Grant service obligation.

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) or TEACH Grant service obligation 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 Signature

Date

DO NOT SUBMIT THIS FORM WITHOUT PHYSICIAN'S CERTIFICATION

You must submit a completed Physician's certification (on page 2) by a licensed physician's with a MD (Doctor of Medicine) or DO (Doctor of Osteopathy or Osteopathic Medicine) medical credential. If the certification is incomplete or unclear, you will be asked to resubmit or provide additional documentation.

PHYSICIAN CERTIFICATION

Physician must be licensed in the U.S. as either Doctor of Medicine (MD) or Doctor of Osteopathy/Osteopathic Medicine (DO)

Last Name First M.I. W00
Student I.D.

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

This referenced student, _____, was previously classified as totally and permanently disabled. The
Print Student Name
student is now requesting financial aid through one of the Federal Aid programs. To be considered for eligibility, the U.S. Department of Education requires that a Physician (**MD or DO**) certify that a borrower is once again able to engage in substantial gainful activity. Substantial gainful activity is defined as a level of work performed for pay or profit that involves doing significant physical or mental activities, or a combination of both. Your completion of this certification will fulfill this requirement.

COMPLETE IF CONFIRMING STUDENT'S GAINFUL ACTIVITY

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

Warning: 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 Signature

Date

COMPLETE IF CONDITION HAS NOT IMPROVED

I certify in my best professional judgment; the condition of the student 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: _____

PHYSICIAN MEDICAL CREDENTIALS

Please select one:

____ MD (Doctor of Medicine)

____ DO (Doctor of Osteopathy/Osteopathic Medicine)

NOTE: The following medical credentials are not acceptable for completing this form and will not be accepted: Doctor of Podiatric Medicine (DPM or podiatrist), Nurse Practitioner (NP), Physician Assistant (PA), Licensed clinical therapist (CMFT, LIMHP, CPC), a Physician from a foreign country unless they are legally authorized to practice in a state, Clinical Psychologist, and Certified Psychologist at the independent practice level. This certification form must be completed by a Physician holding one of the following medical credentials that is legally authorized to practice in a state: MD or DO.