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## **Total and Permanent Disability Discharge: Physician Statement**

|                                                                                                                                              |                    |               |
|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------|
| Name: _____<br>(First, Middle Initial, Last)                                                                                                 |                    |               |
| SSN#: _____                                                                                                                                  | Phone #: _____     |               |
| Email: _____                                                                                                                                 |                    |               |
| <i>I affirm that I have read, understand, and agree to this form in its entirety and that the information supplied is true and complete.</i> |                    |               |
| Student: _____<br>Print Name                                                                                                                 | _____<br>Signature | _____<br>Date |

**You are required to complete this form because you have had prior federal student loans discharged due to total and permanent disability. In order to receive federal student loans at this time, your physician must document your eligibility to engage in substantial gainful activity.**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |       |                             |                                                      |                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-----------------------------|------------------------------------------------------|-------------------|
| By signing this form, the student acknowledges the following:<br><br>Any loans I receive hereafter cannot be canceled in the future on the basis of any present impairment or condition, unless the impairment or condition substantially deteriorates to the extent that the definition of total and permanent disability is met.                                                                                                                                                                                              |       |                             |                                                      |                   |
| SECTION I-TO BE COMPLETED BY CERTIFYING PHYSICIAN (SEE REVERSE FOR INSTRUCTIONS)                                                                                                                                                                                                                                                                                                                                                                                                                                                |       |                             |                                                      |                   |
| Physician's Certification (Check One)<br><br><input type="checkbox"/> I certify that, in my professional medical judgment, the patient/borrower named above is able to engage in substantial gainful activity. (Refer to Physician's Instructions on back of page.)<br><br><input type="checkbox"/> In my professional medical judgment of the patient/borrower named above, I cannot certify that the patient/borrower is able to engage in substantial gainful activity. (Refer to Physician's Instructions on back of page.) |       |                             |                                                      |                   |
| Date borrower became able to work and earn wages (MM/DD/YY): _____                                                                                                                                                                                                                                                                                                                                                                                                                                                              |       |                             |                                                      |                   |
| Type or print physician name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                             | I am legally authorized to practice in the state of: |                   |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | City: | State:                      | Zip Code:                                            | Telephone number: |
| Signature of physician (MD or DO):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |       | Physician's license number: |                                                      | Date:             |

# **Total and Permanent Disability Discharge: Physician Statement**

## General Information:

This form is used to obtain a physician's certification and a borrower's acknowledgement that the borrower is able to engage in substantial gainful activity in order to allow the borrower to secure and repay Federal Direct Stafford Loans (subsidized and unsubsidized) and/or Parent PLUS 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 their disability. The physician has to assess the impact of the borrower's disability on the borrower's ability to earn income in light of what the borrower would be able to earn if 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 such that the borrower is able to engage in substantial gainful activity or attend an institution of postsecondary education, a reaffirmation (reinstatement, no longer in discharge status) can be processed to allow the borrower to regain eligibility for Title IV (federal) student aid.

## Borrower Instructions:

1. The borrower must sign this form.
2. Have Section I of the form completed and signed by a Doctor of Medicine or Doctor of Osteopathy.
3. Please upload this form into your Student Portal or email it directly to [verification@waldorf.edu](mailto:verification@waldorf.edu).

Please retain a copy of this and all other financial aid forms for your records.

## Physician Instructions:

1. Complete this form for the borrower only if you are a Doctor of Medicine or a Doctor of Osteopathy legally authorized to practice in your state.
2. You are being asked to complete, sign and date this form to certify whether the borrower does or does not meet the above definition of total and permanent disability. Please check the box ( ☐ ) beside the statement applicable to the borrower's current condition.

Sources: U.S. Department of Education, "Total and Permanent Disability Discharge," 34 CFR 685.213

"Student Eligibility After TPD Discharge." [www.disabilitydischarge.com](http://www.disabilitydischarge.com). U.S. Department of Education