Student Financial Aid & Scholarships
1621 Dr. Martin Luther King, Jr. Drive
Little Rock, AR. 72202
Phone: (501) 420-1226 Fax: (501) 400-8662
Email: financialaid@arkansasbaptist.edu
Homepage: www.arkansasbaptist.edu
School Code 00108700

Loan Discharged Due to Disability 2016-2017

Student's Name: _____CAMS ID: _____
(Please print) Last First

Our records indicate you have one or more student loans discharged because of a total and permanent disability. If you wish to be considered for additional federal student loans, complete section I and II of this form. This form must be done each year that you want to receive a loan.

Section I: To Be Completed by the Student.

I previously had federal student loan(s) discharged due to total and permanent disability. Since that time, my condition has improved sufficiently to permit me to engage in substantial gainful activity, such as working or attending school. I hereby acknowledge that any new federal student loans I may receive cannot be canceled in the future on the basis of any impairment present when a new federal student loan is made, unless that impairment substantially deteriorates.

Student Signature: _____ Date: _____

Section II: To Be Completed by the student and physician.

I have provided a physician statement to ABC in previous years. ◯ Yes or No ◯

If you answer no, please sign this form as **consent for release of information** and have your physician complete the attached physician statement.

I understand my physician must sign the statement below and I authorize any physician, hospital or other institution having records pertaining to the disability for which I had a loan(s) cancelled to make information from such records available to the U.S. Department of Education or the holder of my loan(s).

Student Signature: _____ Date: _____

LNDSCH-E- Department Use Only

Physician's Certification

To Be Completed By Certifying Physician - (see reverse for instructions and privacy act notice)

Diagnosis of borrower's present medical condition (give results of complications)

Borrower is: Ambulatory Other (please explain)

Prognosis - Is condition static? Yes No - If no, what optimum improvement or deterioration can be expected?

Physician's Certification (Check one)

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 page.)

In my professional medical judgment of the patient/borrower named above, I **cannot** certify that he/she is able to engage in substantial gainful activity. (Refer to Physician's Instructions on back page.)

Name of physician:

Legally authorized to practice in the state of:

Address:

Telephone number:

Physician's license number:

Physician's Signature (M.D. or D.O.)_____ Date:_____

Borrower: Return original to ABC Financial Aid 1621 Dr. Martin Luther King Drive Little Rock, AR 72202
Keep a copy for your records

LNDSCH

Physician's Certification

General Information
This form is used to obtain a physician's certification.
The purpose is to have a licensed physician certify that the borrower is able to engage in substantial gainful activity.
This form will allow the borrower to secure additional loan(s) under one or more of the following William D. Ford Direct Loan: Stafford Student Loan Programs, Parent Loans for Undergraduate Students (PLUS), Consolidation Loans.

Physician Instructions
■ You are being asked to complete, sign and date this form to certify that the borrower is able to engage in substantial gainful activity (e.g., able to work and earn money or attend school).
■ You may complete this form for the borrower only if you are a doctor of medicine or doctor of osteopathy legally authorized to practice in your state.

School Instructions
■ Receipt of this completed form with the appropriate physician's certification satisfies the federal requirements [34 CFR 682.201(a)(5)] for affected borrowers.
■ This completed form must be maintained as part of the student's financial aid records to document his/her eligibility for a Direct Program loan.
■ A copy of this completed form must accompany the loan application when it is sent to Direct Loans. The borrower should retain a copy for their records and the school must keep a copy in the student file.

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 SSN is used as a loan account number (identifier) in order to accurately record necessary information.
■ The routine uses of this information include its disclosure to Federal, State or local agencies, to guaranty 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 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 Direct Program loans.

Submit