FORM APPROVED
OMB NO. 0915-0034
Exp Date: 09/30/2009
See Burden Statement on reverse side

BORROWER DEFERMENT REQUEST

FOR THE HEALTH EDUCATION ASSISTANCE LOAN (HEAL) PROGRAM
Under Title VII, Part A, Subpart I, Public Health Service Act as amended (42 U.S.C. 292-292o)
This form is authorized by Section 705(a)(2)(C) of the Public Health Service Act as amended.

WARNING: Any person who knowingly makes a false statement or misrepresentation in a HEAL transaction, bribes, or attempts to bribe a Federal official, fraudulently obtains a Federal HEAL loan or commits any other illegal action in connection with a Federal HEAL loan is subject to a fine or imprisonment under Federal statute

INSTRUCTIONS

1. Provide the address of your lender.
2. Complete, sign and date Section 1.
3. Select a deferment type in Section 2.
4. For an internship, residency, fellowship or primary care deferment, complete Section 3a. For a school, Peace Corps, voluntary service, National Health Service Corps, indian healthcare, or military deferment, have an appropriate official (listed in Section 3b) complete Section 3b.
5. Return the form to the lender/servicer listed in Section 1.

SECTION 1: BORROWER SIGNATURE

NAME OF BORROWER *(Type or Print)*	ADDRESS *(Number and Street)*		
SOCIAL SECURITY NUMBER	CITY	STATE	ZIP CODE

I request exemption from payment of principal and interest on my Federal HEAL loans. I agree to notify the lender of my deferment (or attendance) status annually, or more frequently if changes occur. I understand that installments of principal and interest need not be paid, but interest shall accrue and may, at the lender's option, be compounded according to the terms of my promissory note.

BORROWER SIGNATURE *(Required for all deferment types)*	Date

Borrower must provide name and address of lender/servicer.

RETURN DEFERMENT FORM TO LENDER OR SERVICER →

NAME _____

ADDRESS _____

_____

SECTION 2: SELECT DEFERMENT TYPE

Please make sure you are eligible for the deferment type you select. CHOOSE ONE ONLY.

I wish to postpone my Federal HEAL loan payments because of:

___ 1. Full time attendance at a HEAL school or a school participating in the Federal Family Education Loan Program

___ 2. Participation in an approved internship or residency

(4 year limit if you got your Federal HEAL loan on or after 10/22/85 or if grace has expired)

___ 3. Full time participation in an approved fellowship training program or educational activity (2 year limit)*

___ 4. Full time voluntary service in the Peace Corps (3 year limit)

___ 5. Full time voluntary service under the Title I Domestic Volunteer Service Act of 1973 (VISTA/ACTION) (3 year limit)

___ 6. Service as a member of the National Health Service Corps (3 year limit)

___ 7. Full time active duty in the Armed Forces (3 year limit)

___ 8. Completed approved internship or residency training in osteopathic general practice, family medicine, general internal medicine, preventive medicine, or general pediatrics and practicing primary care (3 year limit)

___ 9. Graduate of Chiropractic school (1 year limit)

___ 10. Provide health care services to Indians through any health program or facility funded in whole or part by the Indian Health Service for the benefit of Indians (Section 705(a)(2)(C) of the PHS Act. (3 year limit for serve starting 02/01/1999 or later)

** A FELLOWSHIP TRAINING or EDUCATIONAL ACTIVITY* must *be* directly related *to* the discipline for which *you* received your Federal *HEAL* loan, and *must begin within 12 months from the time you left your accredited internship or residency program. It* must *NOT be* part *of, an extension of, or associated with your internship or residency. In addition, the FELLOWSHIP TRAINING must be a formally established fellowship program. You* must *participate full* time *in research training or health care policy, and receive either no stipend, or a stipend not greater* than that *for graduate and professional training under Public Health Service grants.*

IMPORTANT: COMPLETE DEFERMENT CERTIFICATION ON REVERSE SIDE

SECTION 3: DEFERMENT CERTIFICATION

*A. Required for Deferment Types **2, 3** and **8** only. (For deferment type **8**,* indicate when and where primary care residency was completed.)

PROGRAM BEGIN DATE *(Month-Day-Year)*	PROGRAM END DATE *(Month-Day-Year)*	PROGRAM NAME
_____/_____/_____	_____/_____/_____	

HOSPITAL/INSTITUTION NAME	PHONE NUMBER	TYPE OF RESIDENCY SPECIALTY
	( )	
ADDRESS		

CITY	STATE	ZIP CODE	

*B. Required for Deferment Types **1, 4, 5, 6, 7, 9** and **10*** only.

Authorized officials for each deferment type above are: **1** - school registrar: **4** and **5**- a certifying officer in the Division of Volunteer Support ACTION (Washington, DC); **6**- Public Health Service Regional Office Project Officer for the National Health Service Corps; **7**- Military Commanding Officer; or **10**-a certifying official familiar with the funding of the health program or facility.

I certify that the information stated on this form reflects the current status of the borrower or that the borrower graduated _____/_____ (month/year). I also verify that I am qualified to certify this document. The borrower's deferment period begins on _____/___/_____(month/day/year) and ends on _____/___/_____

SIGNATURE OF AUTHORIZED OFFICIAL	DATE	PHONE NUMBER

NAME OF AUTHORIZED OFFICIAL *(Please print)*	TITLE	HEAL SCHOOL CODE *(if applicable)*

SCHOOL OR INSTITUTION NAME	ADDRESS	CITY	STATE	ZIP CODE

REMEMBER: Send this form to lender/servicer listed in Section 1.