

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)
SOCIAL SECURITY NUMBER

ADDRESS (Number and Street)		
CITY	STATE	ZIP CODE

I request exemption from payment of principal and interest on my Federal HEAL loan(s). 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
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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:

- | | |
|---|---|
| <input type="checkbox"/> 1. Full time attendance at a HEAL school or a school participating in the Federal Family Education Loan Program | <input type="checkbox"/> 7. Full time active duty in the Armed Forces (3 year limit) |
| <input type="checkbox"/> 2. Participation in an approved internship or residency (4 year limit if you received your Federal HEAL loan on or after 10/22/85 or if grace has expired) | <input type="checkbox"/> 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) |
| <input type="checkbox"/> 3. Full time participation in an approved fellowship training program or educational activity (2 year limit)* | <input type="checkbox"/> 9. Graduate of Chiropractic school (1 year limit) |
| <input type="checkbox"/> 4. Full time voluntary service in the Peace Corps (3 year limit) | <input type="checkbox"/> 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 service starting 02/01/1999 or later). |
| <input type="checkbox"/> 5. Full time voluntary service under the Title I Domestic Volunteer Service Act of 1973 (VISTA/ACTION) (3 year limit) | |
| <input type="checkbox"/> 6. Service as a member of the National Health Service | |

* A FELLOWSHIP TRAINING or EDUCATIONAL ACTIVITY must be directly related to the discipline for which you received your Federal HEAL loan(s), 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.

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 - 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.

PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0034. Public burden is estimated to average 10 minutes for the borrower and 5 minutes for officials per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-29, Rockville, Maryland 20857.