U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration Bureau of Health Profession

Bureau of Health Profession Rockville, MD 20857

| FORM APPROVED |
|-------------------|
| OMB No. 0915-0036 |
| EXP DATE: |

FEDERAL HEALTH EDUCATION ASSISTANCE LOAN (HEAL) PROGRAM REQUEST FOR COLLECTION ASSISTANCE (42 U.S.C. 292-2920)

DATE OF REQUEST

| PUBLIC BURDEN STATEMENT : A required to respond to a collection of information complete this information collection is estimated the data needed, and complete and review the information. | unless it o | displays a vali e 10 minutes p | d OMB control i | number for t | his informat | ion collectio | n is 0915- | 0036. The time required to |
|---|-------------------------|-----------------------------------|-----------------|----------------------------|--------------|---|------------|----------------------------|
| FROM (Name of Lender) | LENDER IDENTIFICATIC | | | SERVICER IDENTIFICATION | | TO: Debt Management Branch, PSC Health and Human Services 5600 Fishers Lane, Room 11-61 | | |
| STREET ADDRESS | CIT | CITY AND STATE ZIP CODE | | | E | Rockville, MD 20857 | | |
| NAME AND TITLE | | | | ! | | | | ELEPHONE |
| | | | | | | AREA C | ODE | NUMBER |
| We request your assistance on the De | linquen DISCII | | | IIDITY NI II | MDED | TELEPH | ONE | |
| NAME OF BORROWER (Last, First, MI) | DISCI | PLINE | SOCIAL SEC | SOCIAL SECURITY NUMBER | | | ODE | NUMBER |
| MAILING ADDRESS | | | CITY | | | STATE | | ZIP CODE |
| LAST SCHOOL ATTENDED | | | | | ☐ Gra | OOL DATE raduation //ithdrawal | | |
| NAME OF NEAREST RELATIVE | | ADDRESS | | | | | | |
| | | CITY | | STATE | | | ZIP CODE | |
| NAME OF PARENT OR GUARDIAN | | ADDRESS | | | | | | |
| | | CITY | | | STATE | | | ZIP CODE |
| ORIGINAL PRINCIPAL LOAN AMOUNT | UNPAID | PRINCIPAL . | AND INTERES | T PER | CENT INTI | REST NUMBER OF PAYMENTS MADE TO DATE | | |
| REASON FOR THIS REQUEST (Check one) 1a. STUDENT IS DELINQUENT ON MONTHLY PAYMENTS 1b. REFINANCED LOAN Yes No | | | | | | | | |
| NUMBER OF PAYMENTS AMOUNT DUE PER MONTH \$ | | | | | | | | |
| 2. ☐ SKIP | | | | | | | | |
| 3. OTHER (Explain) WARNING: Any person who knowingly ma fraudulently obtains a HEAL loan, or commits an | | | | | | | | |

HRSA-513 (9/05)

statute.