FORM under review 60 day notice
OMB NO. 1845-0128
Exp Date: x/xx/20xx
See Burden Statement on Page 2

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) and Consolidated Appropriation Act, 2014
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

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 eligible to participate in the Title IV Higher Education Act of 1965, as amended programs

☐ 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)

☐ 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
Volunteer Service Act of 1973 (VISTA/ACTION) (3 year limit)

☐ 6. Service as a member of the National Health Service

☐ 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 service 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(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.

PRA Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1845-0128. Public reporting burden for this collection of information is estimated to average 30 minutes response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain benefit (Title VII, Part A, Subpart I of the Public Health Service Act (42 U.S.C. 294m) and the Consolidated Appropriation Act, 2014). If you have comment or concerns regarding the status of your individual submission of this form, please contact the HEAL Program, U.S. Department of Education, 830 First Street NE, Washington, DC, 20202 directly. [Note: Please do not return the completed form to this address.].