OMB Control No. 1845-0124
Expiration Date: DRAFT FOR
60 DAY CLEARANCE

PHYSICIAN'S CERTIFICATION OF BORROWER'S TOTAL AND PERMANENT DISABILITY

WARNING: ANY PERSON WHO KNOWINGLY MAKES A FALSE STATEMENT OR MISREPRESENTATION ON THIS FORM MAY BE SUBJECT TO FINE OR IMPRISONMENT UNDER SECTION 1001 OF THE UNITED STATES CRIMINAL CODE.

GENERAL INSTRUCTIONS

This form is used for obtaining a physician's certification of a borrower's permanent and total disability for the purpose of cancellation of the borrower's obligation to repay his or her student loan(s) obtained under the Health Education Assistance Loan (HEAL) program.

DEFINITION OF TOTAL AND PERMANENT DISABILITY

TO BE TOTALLY AND PERMANENTLY DISABLED THE BORROWER MUST BE UNABLE TO ENGAGE IN ANY SUBSTANTIALLY GAINFUL ACTIVITY BECAUSE OF A MEDICALLY DETERMINABLE IMPAIRMENT THAT IS EXPECTED TO CONTINUE FOR A LONG AND INDEFINITE PERIOD OF TIME OR TO RESULT IN DEATH.

It should be noted that the standard for determining disability for cancellation of the borrower's loan obligation may be different from standards used under other public and private programs in connection with occupational disability or eligibility for social service benefits.

INSTRUCTIONS FOR BORROWER

1. Complete Section I and sign the form. A representative of the borrower may complete this section and sign the form on the borrower's behalf if the borrower is unable to do this because of his or her disability.
2. Have Section II of the form completed and signed by a doctor of medicine or doctor of osteopathy.
3. Return a completed copy(s) of this form to each holder/servicer which has made a loan to you under the Health Education Assistance Loan (HEAL) program.

Before sending to your loan holder/servicer, please, make sure that Section II (Certification of Borrower's Total and Permanent Disability) has been completed. If you are a disabled Veteran, please contact your servicer prior to submission.

INSTRUCTIONS FOR PHYSICIAN

PLEASE NOTE: Complete this form only If you are a doctor of medicine or a doctor of osteopathy legally authorized to practice in your state

1. Complete Section II and sign the certification only If the borrower's condition meets the above definition of total and permanent disability. Please make your report complete, as to the nature, duration and severity of the borrower's present and future impairment. You may attach additional pages if necessary.
2. *Current Medical Evaluation (Not more than 4 months old)*: Report should be detailed to provide for a comprehensive review to determine the nature, duration, and extent of the impairment. Include *supporting documentation* on the history of the illness, medical examinations, and inpatient/outpatient treatments, current medications, past medical records and a prognosis and rehabilitation plan.
3. **Return this form to the borrower listed in Section I.**

Section I – TO BE COMPLETED BY BORROWER OR BORROWER'S REPRESENTATIVE
(See instructions above. See Privacy Act notice on reverse side.)

1. NAME OF BORROWER (Last) (First) (MI)

2. BORROWER'S SOCIAL SECURITY NUMBER

3. NAME AND ADDRESS OF BORROWER OR BORROWER'S REPRESENTATIVE (Print or type)

4. AGE OF BORROWER

5. DATE OF BIRTH MM DD YYYY

_____/_____/_____

6. DATE ENTERED HEAL SCHOOL

MM DD YYYY

_____/_____/_____

7. GRADUATION DATE

MM DD YYYY

_____/_____/_____

8. COURSE OF STUDY

9. EMPLOYMENT HISTORY (since separation from school)

CONSENT FOR RELEASE OF INFORMATION – I authorize any physician, hospital or other institution having records pertaining to the disability for which I am requesting discharge of my loan(s) to make information from such records available to the Department of Education and Health and Human Services and to the holder/servicer of my loan(s). I authorize the Department of Health and Human Services designated physician to contact my physician(s) to receive my medical records and discuss my medical condition**.**

SIGNATURE OF BORROWER OR REPRESENTATIVE

DATE

MM DD YYYY

_____/_____/_____

See Back for Sections II and III

SECTION II – TO BE COMPLETED BY CERTIFYING PHYSICIAN

1. WHEN DID THE BORROWER'S PRESENT ILLNESS OR INJURY START?
MM DD YY
_____/_____/_____

2. WHEN DID THE BORROWER BECOME UNABLE TO WORK AND EARN MONEY?
MM DD YY
_____/_____/_____

3. DIAGNOSIS OF BORROWER'S PRESENT MEDICAL CONDITION.

4. NATURE OF ONSET

5. CURRENT MEDICATIONS

6. REHABILITATION PLANS **(Include any treatment which has not been accepted by the Borrower)**

7. BORROWER IS ☐ AMBULATORY; ☐ BED CONFINED; ☐ HOUSE CONFINED; ☐ HOSPITAL CONFINED; ☐ OTHER_____

8. PROGNOSIS – IS CONDITION STATIC? ☐ YES ☐ NO IF "NO", WHAT OPTIMUM IMPROVEMENT CAN BE EXPECTED

9. PHYSICIAN CERTIFICATION OF BORROWER'S TOTAL AND PERMANENT DISABILITY

I certify that in my best professional judgment (borrower's name_____) is unable to engage in any substantial gainful activity or attend school because of a medically determinable impairment that is expected to continue for a long and indefinite period of time or to result in death.

I am legally authorized to practice in the State of _____.

10. NAME & ADDRESS OF PHYSICIAN *(Print or type)*

11. DATE **MM DD YY**
_____/_____/_____

12. SIGNATURE OF PHYSICIAN (M.D. OR D.O.)

SECTION III – TO BE COMPLETED BY LOAN HOLDER/SERVICER
(Borrower and Physician leave blank)

1. LOAN HOLDER/SERVICER NAME	2. 2. LOAN HOLDER/SERVICER ADDRESS

3. TOTAL AMOUNT OF UNPAID BALANCE	4. DATE PREPARED BY HOLDER/SERVICER **MM** **DD** **YYYY**
$_____	_____/_____/_____

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.

1. The authority for collecting the information requested on this form is found in 34 CFR 681.39 (b) and 685.213 and the Consolidated Appropriations Act, 2014.
2. The principal purposes of this information are to verify the identity of the borrower; eligibility for loan cancellation; and in the event it is necessary to locate the borrower's representative or certifying physician. The SSN is used as a loan account number (identifier) in order to accurately record necessary information.
3. The routine uses of this information include its disclosure to Federal, State or local agencies, to guarantee 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 the borrower's eligibility for loan cancellation; investigating possible fraud and verifying compliance with program regulations. Failure to provide the requested information may cause the Department of Education to deny the borrower's request for loan cancellation.
4. This information is necessary to process requests for loan cancellation.

HEAL 539 (BACK)