

U. S. DEPARTMENT OF EDUCATION  
Federal Student Aid

OMB No. 1845-0127  
EXP DATE: **Form**  
**Under Review**

**FEDERAL HEALTH EDUCATION ASSISTANCE LOAN  
(HEAL) PROGRAM**

DATE OF REQUEST

**REQUEST FOR COLLECTION ASSISTANCE  
(42 U.S.C. 292-2920) and the Consolidated Appropriation Act,**

**2014**

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 1845-0127. Public reporting burden for this collection of information is estimated to average 10 minutes per 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 Appropriations 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.]

FROM (Name of Lender)		LENDER IDENTIFICATION	SERVICER IDENTIFICATION	TO: Department of Education, Program Support Center (PSC) Accounting Services – Debt Collection	
STREET ADDRESS		CITY AND STATE	ZIP CODE	7700 Wisconsin Avenue, Mail Stop 10230B Suite 8-8110D Bethesda, MD 20857	
NAME AND TITLE			TELEPHONE		
			AREA CODE	NUMBER	
<b>We request your assistance on the Delinquent Borrower below:</b>					
NAME OF BORROWER (Last, First, MI)		DISCIPLINE	SOCIAL SECURITY NUMBER	TELEPHONE	
				AREA CODE	NUMBER
MAILING ADDRESS		CITY	STATE	ZIP CODE	
LAST SCHOOL ATTENDED		SCHOOL IDENTIFICATION	SCHOOL DATE		
			<input type="checkbox"/> Graduation _____ <input type="checkbox"/> Withdrawal _____		
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 INTEREST	PERCENT INTEREST	NUMBER OF PAYMENTS MADE TO DATE		
REASON FOR THIS REQUEST (Check one)					
1a. <input type="checkbox"/> STUDENT IS DELINQUENT ON MONTHLY PAYMENTS		1b. REFINANCED LOAN Yes <input type="checkbox"/> No <input type="checkbox"/>			
NUMBER OF PAYMENTS		AMOUNT DUE PER MONTH			
		\$			
2. <input type="checkbox"/> SKIP					
3. <input type="checkbox"/> OTHER (Explain)					
<b>WARNING:</b> Any person who knowingly makes a false statement or misrepresentations in a HEAL loan transaction, bribes or attempts to bribe a Federal official, fraudulently obtains a HEAL loan, or commits any other illegal action in connection with a HEAL loan, is subject to possible fine(s) and imprisonment under Federal statute.					