LOUISIANA TECH UNIVERSITY
Office of Financial Aid

Physican's Certification 2022-2023

Please return this completed form to:
Louisiana Tech University
Office of Financial Aid
PO Box 7925 Ruston, LA 71272

BORROWER'S Last Name | First Name | MI

BORROWER'S SSN

BORROWER'S Mailing Address (include Apt. No.)

BORROWER'S Date of Birth (MM/DD/YYYY)

City | State | Zip Code

BORROWER'S Home Phone (Include area code)

BORROWER'S Email Address

BORROWER's Cell Phone (Include area code)

Instructions for Physician: The borrower identified above is applying to receive a Federal Student Aid (FSA) loan. The borrower has previously received a Federal Family Education Loan Program (FFELP) and/or FSA loan cancellation based on a finding that he/she was disabled. You are being asked to complete this form to certify that the borrower is now able to engage in substantial gainful activity (borrower is sufficiently physically recovered to be capable of attending school, successfully completing a program of study, and securing employment). You may complete and sign this form **only** if you are a **doctor of medicine or osteopathy** and legally authorized to practice in a state. Please type or print in dark ink. Sign the certificate (a signature stamp is not acceptable) only if the borrower's condition allows him/her to engage in substantial gainful activity. Once complete, return the original completed form to the borrower or the borrower's representative. The borrower will forward the form to the university.

When did you last examine the borrower? (MM/DD/YYYY):

Diagnosis of the borrower's present medical condition - specify the nature, duration, and severity of the borrower's present and future impairments:

I certify that in my best professional judgement, the borrower identified above is currently able to engage in substantial gainful activity.

I am a (select one) ☐ Doctor of Medicine ☐ Doctor of Osteopathy legally authorized to practice in the State of .

PHYSICIAN'S Last Name | First Name | MI

PHYSICIAN'S Professional License Number

PHYSICIAN'S Mailing Address (include Apt. No.)

PHYSICIAN'S Telephone (include area code)

City | State | Zip Code

PHYSICIAN'S Fax (Include area code)

Physician's Signature:

Date: