LOUISIANA TECH UNIVERSITY
Office of Financial Aid
Borrower's Acknowledgment and Physician's Certification 2026-2027

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

The National Student Loan Data System (NSLDS) indicates that you have one or more students discharged because of a total and permanent diability. **Before you can receive additional federal student loans**, this form must be completed and returned to the Louisiana Tech University Office of Financial Aid.

Warning: If you receive student aid based upon incorrect information, you may have to return the funds and/or pay fines and fees. If you purposefully give false or misleading information on this form, you may be fined $2000.00, receive a prison sentence, or both.

Section 1: To be completed by the Student (Borrower). See page 2 for instructions and Privact Act Notice.

BORROWER'S Last Name | First Name | MI

BORROWER'S CWID/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)

Affirmation and Consent for Release of Information:

By signing below, I certify that all information I have submitted is accurate and verified with supporting documentation. I further authorize any physician, hospital, or other institution having records pertaining to disability for which I had a loan(s) cancelled to make information from such records available to the U.S. Department of Education or the holder of my loan(s). I further acknowledge that pursuant to 34 C.F.R. 682.201(a)(6)(ii) any loans I receive hereafter cannot be cancelled in the future on the basis on any present impairment or condition, unless the impairment or condition substantially deteriorates to the extent that the definition of total and permanent disability is met.

Borrower's Signature: **Date:**

Section 2: To be completed by the certifying physician (see page 2 for instructions and Privacy Act Notice).

Physician's Certification (check only one box):

☐ I certify that in my professional medical judgment, the patient/borrower named above is able to engage in substantial gainful activity and can attend school. I have attached my statement on official office letterhead. *(Refer to Physicians's Instructions on page 2)*

☐ In my professional medical judgment of the patient/borrower named above, I cannot certify that he/she is able to engage in substantial gainful activity and can attend school. I have attached by statement on official office letterhead. *(Refer to Physician's Instructions on page 2)*

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 Licensing State

DATE Borrower became able to work and earn wages: (MM/DD/YYYY)

DATE you last examined the Borrower:

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

Physician's Signature: **Date:**

GENERAL INFORMATION

This form is used to obtain a physician's certification and a borrower's acknowledgment. The purpose is to have a licensed physician certify that the borrower is able to engage in a substantial gainful activity and to have the borrower acknowledge that any federal student loans received as a result of this physician's certification cannot be canceled based on any present impairment or condition, unless that impairment or condition substantially deteriorates to the extent that the definition of total and permanent disability is met. This form will allow the borrower to secure additional loan(s) under one or more of the following Federal Loan Progam: Stafford Loans, PLUS Loans for Parents.

DEFINITION OF TOTAL AND PERMANENT DISABILITY

To be totally and permanently disabled the borrower must be unable to work and earn money or attend school because of any injury or illness that is expected to continue indefinitely or result in death. This definition calls for a judgment decision as to the borrower's abilty to earn income despite his or her disability. The physician is to assess the impact of the borrower's disability on his or her abilty to earn income in light of what the borrower would normally be able to earn if he or she were not disabled. If the disability appears to have a significant adverse effect the borrower's earning potential, not only in the type of work performed before the impairment but for any substantial gainful employment, and the disability is expected to last for a long and indefinite period of time, then the borrower shall be considered permanently disabled under this definition. If, however, the borrower's condition has improved so that the borrower is able to engage in substantial gainful activity or attend an institution of post secondary education, a reaffirmation (reinstatement, no longer in discharge status) can be processed to allow the borrower to complete procedures for eligibility for Title IV Federal Student Aid.

BORROWER INSTRUCTIONS

- The borrower must complete Section 1
- Have Section 2 of the form completed and signed by a **Doctor of Medicine or a Doctor of Osteopathy**.
- Return this completed form to the Louisiana Tech University Office of Financial Aid along with the Doctor's statement on their office letterhead using the contact information on page 1 of this form

It is recommended that you keep a copy of this and all other financial aid forms for your records. You may need to provide a copy of this statement as evidence of your eligibility for future student loans.

PHYSICIAN'S INSTRUCTIONS

- You may complete this form for the borrower **only if you are a Doctor of Medicine or Doctor of Osteopathy legally authorized to practice in your state**.
- You are being asked to complete, sign and date this form to certify whether the borrower does or does not meet the above definition of total and permanent disability. Please check the appropriate box beside the statement applicable to the borrower's condition.
- Please include a typed/written statement on official physician's office letterhead signed by you, the certifiying physician.

PRIVACY ACT NOTICE: The Privacy Act of 1974 (5 USC 522a) requires that an agency provide teh following notice to each individual whom it asks to supply information.

The authority for collecting the information requested on this form is found in 20 USC 1087, 42 USC 2094k and 22 USC 2601.

- The principal purpose of this information is to verify the identity of the borrower; determine that the borrower is able to engage in substantial gainful activity, and in the event it is necessary, to the borrower's certifying physician.
- The routine uses of this information include its disclosure to Federal, State, or local agencies, to guaranty agencies, to educational physician; determining that the borrower is able to engage in substantial gainful activity; investigating possible fraud and verifying compliance with program regulations. Failure to provide the requested information may result in denial of the borrower's new loan request.
- This information is necessary to process requests for new Federal Loan Programs.