ARKANSAS STATE UNIVERSITY BEEBE
HEBER SPRINGS • LRAFB • ONLINE • SEARCY

TOTAL AND PERMANENT DISABILITY DISCHARGE VERIFICATION FORM

Student's Name: ______________________________ Student ID#/SSN: ______________________

This form serves to reestablish your eligibility for Federal Direct Student Loan Program when prior loans have been discharged due to total and permanent disability. Completion of this form does not guarantee that you will qualify for the Federal Direct Student Loan Programs. Make sure you've read about TPD Discharge here: https://studentaid.gov/manage-loans/forgiveness-cancellation/disability-discharge.

COMPLETE IF YOU *DO NOT* INTEND TO PURSUE YOUR FEDERAL LOAN ELIGIBILITY

☐ No, I am not interested in receiving Federal Loans.

☐ I am not interested in receiving loans, but am interested in federal grants and/or Federal Work Study.

COMPLETE IF YOU *DO* INTEND TO PURSUE YOUR FEDERAL LOAN ELIGIBILITY

☐ Yes, I am interested in receiving Federal Direct loans and will be submitting my Physician Certification to verify my eligibility.

☐ Yes, I am interested in receiving Federal Direct loans and have a Physician Certification on file from the previous year. (If certification is over a year old, new certification must be obtained.)

I acknowledge that I have previously received a total and permanent disability discharge either through the VA, the Federal Family Education Loan Program, William D. Ford Federal Direct Loan Program, or Federal Perkins Loan Program. By my signature below, I clearly understand that any additional student loans I receive must be repaid in full and cannot be canceled in the future on the basis of any impairment present when the new loan is made unless that impairment substantially deteriorates as determined by my physician. I also understand that if I receive a new student loan under the Direct Loan Program, I'll lose my TPD discharge and have my previously discharged loans reinstated if I'm still in my three-year post-discharge monitoring period after my TPD loan discharge was approved.

CONSENT FOR RELEASE OF INFORMATION: I authorize any physician, hospital, or other institution having records pertaining to the disability for which I previously received cancellation of my loan(s) to make information from such records available to the Financial Aid Office, the U.S. Department of Education, or the holder of my loan(s).

AID YEAR: __________ – __________

Student Signature: ____________________________________ Date: ___________________

ASU-Beebe Financial Aid Office
P.O. Box 1000
Beebe, AR 72012
finaid@asub.edu
501-882-8845

PHYSICIAN CERTIFICATION

Student's Name: ___________________________________ Student ID/SSN#: _________________________

Physician certification required for Federal Student Loan Programs after a Previous Permanent Disability Discharge

This referenced student, ___________________________, was previously classified as totally and
Print Student Name
permanently disabled and as a result of this condition, received a total discharge of his/her federal student loan indebtedness. The borrower is now requesting financial aid from one of the Federal education loan programs. The U.S. Department of Education requires that a physician certify that a borrower is once again able to engage in substantial gainful activity, i.e., the person has sufficiently recovered to be capable of attending school, successfully completing a program of study, and securing employment in order to repay the loan he/she is seeking. Your completion of this section will fulfill this requirement.

COMPLETE IF CONFIRMING STUDENT'S GAINFUL ACTIVITY

I certify in my best professional judgment that the above-named student is able to engage in substantial gainful activity as defined by the U.S. Department of Education.

Warning: Previous student loan debts have been canceled due to Total and Permanent Disability. Certification of this form enables the borrower to obtain additional student loans. Any person who knowingly makes a false statement or misrepresentation on this form shall be subject to penalties which may include fines or imprisonment under the United States Criminal Code and 20USC1097.

____ ______________________
Physician Signature Date

COMPLETE IF CONDITION HAS NOT IMPROVED

I certify in my best professional judgment; the condition of the student has not improved enough to allow him or her to engage in substantial gainful activity.

____ ______________________
Physician Signature Date

PHYSICIAN CONTACT INFORMATION

Please type or print the following:

Physician Name: ____

Address of Practice: ____

City, State, Zip Code: ____

Office Phone Number: ____

For FA Office Use Only

Approved: ______________________ Denied: _____________________