

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

PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0204. Public reporting burden is estimated to average 5 minutes for the borrower, 10 minutes for the lender, and 30 minutes for the physician per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-33, Rockville, Maryland 20857.

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	INSTRUCTIONS FOR PHYSICIAN
<p>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.</p> <p>2. Have Section II of the form completed and signed by a doctor of medicine or doctor of osteopathy.</p> <p>3. Return a completed copy(s) of this form to each lender which has made a loan to you under the Health Education Assistance Loan (HEAL) program.</p> <p>Before sending to lender, please, make sure that Section II (Certification of Borrower's Total and Permanent Disability) has been completed.</p>	<p>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.</p> <p>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.</p> <p>2. <i>Current Medical Evaluation (Not more than 4 months old):</i> Report should be detailed to provide for a comprehensive review to determine the nature, duration, and extent of the impairment. Include <i>supporting documentation</i> on the history of the illness, medical examinations, and inpatient/outpatient treatments. Current medications, past medical records, and a prognosis and rehabilitation plan.</p> <p>3. Return this form to the borrower listed in Section I.</p>

SECTION I - TO BE COMPLETED BY BORROWER OR BORROWER'S REPRESENTATIVE <i>(See instructions above. See Privacy Act notice on reverse side.)</i>			
NAME OF BORROWER (Last) (First) (MI)		2. BORROWER'S SOCIAL SECURITY NUMBER	
NAME & ADDRESS OF BORROWER OR BORROWER'S REPRESENTATIVE (Print or type)		4. AGE OF BORROWER	
		5. DATE OF BIRTH MM DD YY ____/____/____	
6. DATE ENTERED HEAL SCHOOL MM DD YY ____/____/____	7. GRADUATION DATE MM DD YY ____/____/____	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 Health and Human Services and to the holder 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.			
10. SIGNATURE OF BORROWER OR REPRESENTATIVE		11. DATE MM DD YY ____/____/____	

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 <input type="checkbox"/> AMBULATORY; <input type="checkbox"/> BED CONFINED; <input type="checkbox"/> HOUSE CONFINED; <input type="checkbox"/> HOSPITAL CONFINED; <input type="checkbox"/> OTHER _____	
8. PROGNOSIS - IS CONDITION STATIC? <input type="checkbox"/> YES <input type="checkbox"/> 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 _____) 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 LENDER
 (Borrower and Physician leave blank)**

1. LENDER NAME _____	2. LENDER ADDRESS _____ _____ _____
3. TOTAL AMOUNT OF UNPAID BALANCE \$ _____	4. DATE PREPARED BY LENDER MM DD YY _____ / _____ / _____

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 collectin the information requested on this form is found in Title VII, Part A, Subpart I of the Public Health Service Act (42 U.S.C. 294m).
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 pupose 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 Health and Human Services to deny the borrower's request for loan cancellation.
4. This information is necessary to process requests for loan cancellation.