2022-2023
FAIA97

PHYSICIAN'S CERTIFICATION AND BORROWER'S ACKNOWLEDGEMENT OF OBLIGATION

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 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 the Federal Direct Student Loan Programs at American River College.

Consent for Release of Information: I authorize any physician, hospital or other institution having records pertaining to the 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).

TO BE COMPLETED BY BORROWER (*STUDENT*):

(1) _____ (2) _____
Print: Name of borrower (First, Last, MI) **Student ID#**

By signing this form, I acknowledge that any loans I receive hereafter cannot be cancelled in the future on the basis of 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.

(3) _____ (4) _____
Student's Signature **Date**

Return this completed form to the financial aid office at American River College. It is recommended that you keep a copy of this and all other financial aid forms for your own records. You may need to provide a copy of this statement as evidence of your eligibility for future student loans.

PHYSICIAN'S CERTIFICATION:

You are being asked to complete, sign and date this form to certify that the borrower is able to engage in substantial gainful activity (e.g., able to work and earn money or attend school)

I certify that in my best professional judgment, my patient, _____,

☐ is **able** to engage in substantial gainful employment or activity.

☐ is **unable** to engage in substantial gainful employment or activity.

I am a doctor of (*check one*) _____ Medicine _____ Osteopathy / Osteopathic medicine.

I am legally authorized to practice in the state of _____ My professional license number is _____.

_____ _____ (___)_____
Physician's Signature **Date** **Telephone**

Please use physician's stamp if available, or complete the information below: **Physician's stamp here below:**

_____
Physician's Name Print: (*First, Middle Initial, Last*)

_____
Name of Medical Office

_____
Address, City, State, Zip Code