

PHYSICIAN'S AFFIDAVIT OF TEMPORARY TOTAL DISABILITY

Name of Claimant (last, first, middle)	SOCIAL SECURITY NO	DATE OF BIRTH
Address of Claimant:		

Under the National Direct/Perkins Student Loan Program, administered by the US Department of Education, a borrower is entitled to have periodic installment payments of principal deferred for up to three years during which the borrower is temporarily totally disabled, or unable to secure employment because he/she is caring for a spouse or dependent who is temporarily totally disabled. To qualify for this deferment, a borrower must provide the lender who issued the loan with an affidavit of a qualified physician, (M.D. or D.O.) certifying the borrower's (or spouse's) disability.

The following affidavits are for the purpose of establishing the eligibility of a National Direct/Perkins Student Loan program borrower to obtain a deferment for temporary total disability and are in a form acceptable to the US Department of Education.

1. If the patient is a borrower of a National Direct/Perkins Student Loan Program:

I certify that, in my best professional judgment, my patient, _____ is temporarily totally disabled as a result of illness or injury and is unable either to attend school or to be gainfully employed. The nature of this patient's illness is _____.

The patient's temporary total disability began on _____. I anticipate that this patient will recover from this disability to the extent that he/she will be able to be gainfully employed or to attend school by _____.

(List Month/Year)

2. If the patient is the spouse or dependent of a National Direct/Perkins Student Loan Program Borrower:

I certify that, in my best professional judgment, my patient, _____, who is the spouse of _____, is temporarily totally disabled as a result of an illness or injury and is unable to be gainfully employed. In addition, this patient requires continuous nursing or other similar services. The nature of this patient's illness is _____.

This patient's temporary total disability began on _____. I anticipate that this patient will recover from this disability to the extent that he/she will be able to be gainfully employed and will no longer require continuous nursing or other similar services by _____.

(List Month/Year)

TO BE COMPLETED BY M.D. OR D.O.

I am legally authorized to practice medicine/osteopathy in the State of _____.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Physician's Name (Please type or Print) _____

Signature of Physician (M.D. or D.O.) _____ Date _____

Address: _____

Street City, State Zip

Telephone: _____

FOR OFFICE USE ONLY:

Approved For Period _____

Disapproved _____

Signed _____, Title _____, Date _____

DISABTEMP.DOC 2/99

RETURN COMPLETED FORM TO:
 Minnesota State Colleges & Universities
 FINANCIAL COLLECTIONS
 Wells Fargo Place
 30 7th St E., Suite 350
 St Paul, MN 55105-7804

Tel: 651-917-4700 Fax: 651-917-4711 Website: www.slsc.mnscu.edu