UHD ID: _____ Student's First Name: _____ Last Name: _____

University of Houston DOWNTOWN

Office of Scholarships and Financial Aid

2024-2025 Disability Discharge Borrower Acknowledgement

Eligibility Reinstatement Form for Federal Student Loan Programs after a previous Total and Permanent Disability Discharge

This form serves to reestablish your eligibility for Federal Student Loan Programs 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 Student Loan Programs.

In order to be considered for a federal student loan you must print, complete and return this form to the financial aid office.

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

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

Signature_____ Date:_____

COMPLETE IF YOU WISH TO PURSUE YOUR FEDERAL LOAN ELIGIBILITY

☐ Yes, I am interested in receiving federal direct loans and will have my physician complete the Physician Certification section of this form.

I acknowledge that I have previously received a total and permanent disability discharge either through 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. Also they cannot be canceled in the future on the basis of any impairment when the new loan is made unless that impairment substantially deteriorates, as determined by my physician.

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 to the holder of my loan(s).

Signature_____ Date:_____

PHYSICIAN CERTIFICATION

PHYSICIAN SECTION

The referenced student _____, was previously classified as totally and 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 is 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.

UHD ID: _____ Student's First Name: _____ Last Name: _____

Please continue to next page

COMPLETE IF CONFIRMING STUDENT'S GAINFUL ACTIVITY	
I certify in my best professional judgement 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 cancelled 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:
Date permitted to return to substantial gainful activity:	

COMPLETE IF CONDITION HAS NOT IMPROVED	
I certify that, in my best professional judgement, the condition of the student named above has not improved enough to allow him or her to engage in substantial gainful activity.	
Physician Signature:	Date:

PHYSICIAN CONTACT INFORMATION		
I certify that the information provided herein is true and correct to the best of my knowledge. I also understand that if I purposely give false or misleading information in connection with this application for federal aid, I may be subject to a fine of up to $20,000, sent to prison, or both.		
Physician Signature:	Physician Phone Number:	Date:
Address of Practice:		
I am a doctor of (Check One) ☐ Medicine ☐ Osteopathy		License #