

Total and Permanent Disability Borrower's Acknowledgement

Borrower's Name:	
Student ID Number:	Last 4 of SS Number
Date of Birth:	
Federal Direct Loan cancellation applying to receive a Federal Dir	(Federal Family Education Loan Program) and/orn based on total and permanent disability. I am now Direct student loan. Pursuant to 34 C.F.R. §682.201 he Direct loan for which I am applying cannot be basis of any impairment present when the new loan ete my educational program, unless that impairment
Borrower's Signature	Date
Address	
City, State, Zip	
Telephone Number	Email Address

Send this form to:

Alcorn State University Office of Student Financial Aid 1000 ASU Drive, 28 Alcorn State, MS 39096-7500

Fax: 601-877-6110

Email: asufinaid@alcorn.edu



Total and Permanent Disability PHYSICIAN'S CERTIFICATION

Dorrower's Name:	Date of	Dirui:
Instructions for Physician: The borrower identified Federal Family Education Loan Program and/or Federal Federal Direct loan cancer being asked to complete this form to certify that the bi.e., able to work and earn money. You may complete osteopathy legally authorized to practice in a state signature stamp is not acceptable) only if the borrower activity.	ederal Direct Loan Program. ellation based on a finding that corrower is now able to engage e and sign this form only if your Please type or print in dark	The borrower has previously he/she was disabled. You are in substantial gainful activity, u are a doctor of medicine or ink. Sign the certification (a
*Once completed, return (by mail) the original comp The borrower will forward the form to this agency.	sleted form to the borrower or	the borrower's representative.
*When did you examine the borrower? (MM-DD-YY	YYY)	
*Diagnosis of the borrower's present medical con borrower's present and future impairments:	adition – specify the nature,	duration and severity of the
I certify that, in my best professional judgment, the substantial gainful activity (able to work and earn modern and a (check one)doctor of medicinedoctand my professional	oney). or of osteopathy legally author	rized to practice in the state of
Physician's Signature Address	Name (Printed)	Date
City, State, Zip	Telephone	

Student (Patient) must send completed form to:

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