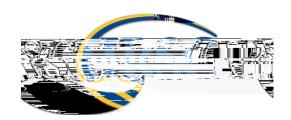
Indian River State College Office of Student Financial Aid 2024 – 2025 Academic Year



Physician's Certification

Student Name:	Student ID Number: _	
The purpose of this form is for the licactivity and to have borrower acknown certification cannot be canceled based deteriorates to the extent that the de	inpleted the FAFSA to apply for Federal Student censed physician to certify that the student borrowledge that any federal loans and/or Teach Ged on any present impairment or condition, unless finition of total or permanent disability is met. The or more of the following Federal Loan Programment Grant.	rower is able to engage in substantialfugain brant, received as a result of this physicians as that impairment or condition substalptial. This form will allow the borrowesecure

PrivacyActNotice: The PrivacyAct of 1974 (5 U.S.C522A) required that an agencyprovide the following notice to each individual whom it asks to supply information.

- x Theauthority for collecting the information requested on this form is found in 20 U.S.C.1087, 42 U.S.C.209 4k and 22 U.S. C. 2601.
- x Theprincipal purpose of this information is to verify the identity of the borrower; determine that the borrower is able to engage in substantial gainful activity; and in the event it is necessary, to locate the borrower's certifying physician.
- x The routine uses of this information include its disclosure to Federal, State, or local agencies, to guaranty agencies, to education and financial institutions, and to agency contractors for the purpose of verifying the identity of the borrower and the borrower's physician; determining that the borrower is able to engage substantial gainful activity; investigating possible frauthd verifyingcompliance with programregulations. Failure to provide the requested information may result in denial of the borrower's new loan request.
- x This information is necessary to process requests for new Federal Loan Programs and or Teach Grant.

id Name of Physician:		License Number:	
ui Name of Fifysician.			
am legally authorized to practice in the state of	of:		
address of Practice:			
Street Address	City	State/Zip Code	
mail Address:	Best Contact Number:		

Date patien p in 2.6ro.8 (i3 (ai)-0.9()5 (p)5.3 (at)7.2 (i)4.2 2-2.c)0.7 112.1717 18 (a)-3.7 (t)thn 2.61 .8 (u)0.7 (I)ጜር (ፍ) ችህ (አ) መርታና (ነን ከታ ሀ (፲፱፮) - 3.7 (t) አን ይር (ቀ) ቼ ዴጳ/አፄ/ኒንኔ (፣) ይመረ (ቀ) መርታና (ነን መርታ