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

Physician's Certification

Student Name: ______________________________________ Student ID Number: _________________________

The above-referenced student has completed the FAFSA to apply for Federal Student Aid for the 2024-2025 academic school year. The purpose of this form is for the licensed physician to certify that the student borrower is able to engage in substantial gainful activity and to have borrower acknowledge that any federal loans and/or Teach Grant, received as a result of this physicians' 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 or permanent disability is met. This form will allow the borrower to secure additional loans and/or grants under one or more of the following Federal Loan Programs: Federal Direct Student Loans, Parent Plus Loans, Consolidation Loans, and/or Teach Grant.

Privacy Act Notice: The Privacy Act of 1974 (5 U.S.C 522A) required that an agency provide the following notice to each individual whom it asks to supply information.

- The authority 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.
- The principal 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.
- 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 fraud, and verifying compliance with program regulations. Failure to provide the requested information may result in denial of the borrower's new loan request.
- This information is necessary to process requests for new Federal Loan Programs, and or Teach Grant.

Physician's Certification: To be complete and signed by the certifying physician only

Full Name of Physician: ____ License Number: _________________

I am legally authorized to practice in the state of: ____

Address of Practice: ____

Street Address City State/Zip Code

Email Address: _____________________________________ Best Contact Number: ___________________________

___Yes, in my professional medical judgement of the patient/borrower named above, and in accordance with the purposes of this form and the definition of a Total and Permanent Disability (see first page), I certify that the patient/borrower is able to engage in substantial gainful activity and can attend school.

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