

**Total and Permanent Disability Discharge  
Borrower Acknowledgment and Physician's Certification**

**Student's Name:** \_\_\_\_\_ **USC ID:** \_\_\_\_\_

The National Student Loan Data System (NSLDS) indicates that you have one or more federal student loans canceled or forgiven due to a total and permanent disability. If you want to borrow new federal student loans, you must complete this review annually, with each new FAFSA application, as required by federal regulation. If you do not want to borrow loans but want to be considered for federal grants only, contact your campus Financial Aid Office.

**Borrower Acknowledgment (To be completed by the student)**

*By signing, I acknowledge and agree that any future federal student loans that I obtain under the Higher Education Act of 1965, as amended, cannot be canceled, or forgiven based on any impairment present when the new loan is made, unless that impairment substantially deteriorates. Additionally, I authorize the representatives of the University of South Carolina's Financial Aid Office to contact my physician to verify the information provided.*

**Student's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Certification (To be completed by a legally licensed physician\*)**

Physician's Name: \_\_\_\_\_

Address of Practice: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I certify that the applicant's disability has improved, and that the applicant can engage in substantial gainful activity\* as defined by the U.S Department of Education (see definition below).

I certify that, in my best professional judgment, the condition of the student named above has not improved enough to allow him or her to engage in substantial gainful activity\*.

\*For Title IV aid purposes, the phrase "substantial gainful activity" means a level of work performed for pay that involves doing significant physical or mental activities or a combination of both. If a physician's certification does not appear to support this status, the school will contact the physician for clarification.

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*The U.S. Department of Education (ED) requires the necessary certification must be provided by a physician who is a Doctor of Medicine (DM) or a Doctor of Osteopathy (DO) and who is legally authorized to practice in a state. **Warning:** Any person who knowingly makes a false statement of misrepresentation on this form shall be subject to penalties, which may include fines or imprisonment under the United States Criminal Code.

**Financial Aid Office Use Only**

Satisfy tracking requirement on RRAAREQ

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**Counselor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_