

MARQUETTE UNIVERSITY
OFFICE OF STUDENT FINANCIAL AID

2003-2004

**Eligibility Reinstatement Form for
Federal Student Loan Programs after a
Previous Total and Permanent Discharge**

(Doc. 45)

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.

STUDENT SECTION

Borrower Name (Please Print): _____

Borrower Social Security Number: _____

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 and cannot be canceled in the future on the basis of any impairment present 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 Marquette University, the U.S. Department of Education, or to the holder of my loan(s).

Student Signature

Date

PHYSICIAN SECTION

The above referenced borrower 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. As stated in the Student Section above, 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.

I certify in my best professional judgment that the above named student is able to engage in substantial gainful activity as defined by the U.S. Department of Education.

Physician Signature

Date

Please type or print the following:

Physician Name: _____

Address of Practice: _____

City, State, Zip Code: _____

Office Phone Number: () _____

LO 02-74

1212 Building, 415 P.O. Box 1881 Milwaukee, WI 53201-1881

Telephone: 414-288-7390 Fax: 414-288-1718

E-mail: financialaid@marquette.edu