Lakeland
COMMUNITY COLLEGE

Direct Loan Discharge Form

The U.S. Department of Education indicates that you have one or more student loans discharged because of a Total and Permanent Disability. Before you can receive additional federal student loans, this form must be completed and returned to Lakeland Community College's Financial Aid Office.

- **If you do NOT want to borrow federal student loans, complete this section only and submit this form to the Lakeland Financial Aid Office.**

Student's Signature: _____ Date: _____

Lakeland ID (LID) Number: _____ Phone Number: (_____) _____

- **If you want to borrow federal student loans, you must complete the "Student Certification" below. A legally licensed physician must also complete the "Physician Certification" below certifying you have the ability to engage in substantial gainful activity and can attend school.** The Physician's Office must mail this completed form to Lakeland's Financial Aid Office.

Student Certification:

I certify that I have had prior student loan(s) discharged due to Total and Permanent Disability. I understand that any new federal student loan(s) I may borrow cannot be discharged due to my current disability unless my condition significantly deteriorates as verified by a state-licensed physician.

I am fully aware that if I have been granted a student loan discharge due to Total and Permanent Disability within the last three years, and I am currently in the "three-year conditional discharge period," borrowing additional student loans may void my prior discharge.

Student's Printed Name: _____ Lakeland ID (LID) Number: _____

Student's Signature: _____ Date: _____

Physician Certification (check one):

- ❑ I certify that in my professional medical judgement, the patient/borrower named above is able to engage in substantial gainful activity and can attend school.
- ❑ In my professional medical judgement of the patient/borrower named above, I **cannot** certify that he/she is able to engage in substantial gainful activity and can attend school.

Physician's Printed Name: _____

I am legally authorized to practice in the State of: _____ Physician's License Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician's (M.D. or D.O.) Signature: _____ Date: _____

Physician must mail this form (*cannot be faxed*) to:

Lakeland Community College
Financial Aid Office
7700 Clocktower Drive
Kirtland, OH 44094-5198

_____ *For Office Use Only* _____

Date Completed: _____ Initials: _____

Comments: _____