UNC GREENSBORO
Financial Aid *and* Scholarships

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PHYSICIAN CERTIFICATION OF BORROWER'S SUBSTANTIAL GAINFUL ACTIVITY

The student listed below has previously had Federal Student Aid (FSA) Loans discharged due to permanent and total disability claim approved by the U.S .Department of Education. The student is now applying for a new FSA loan or TEACH grant for attendance at The University of North Carolina at Greensboro. Per Department of Education guidelines, the student is required to obtain a physician's certification that they have the ability to engage in substantial gainful activity. 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.

Student Name: _____ Student ID: _____

INSTRUCTIONS FOR PHYSICIAN

- Complete this form only if you are a doctor of medicine or osteopathy legally authorized to practice in a state.
- Type or print in dark ink. All fields must be completed, if applicable. Your signature date must include month, day, and year (mm-dd-yyyy).

If you make any changes to the information you provide in this form, you must initial each change.
Please return the completed form to the student for processing with their new FSA loan or TEACH grant application.

PHYSICIAN'S CERTIFICATION

I am a doctor of (check one): ☐ medicine ☐ osteopathic medicine

State of Professional Registration _____

Professional Registration Number: _____

Note: If the student is able to work, and earn money in any capacity in any field of work, even if only on a limited basis, you must indicate that the student *is* capable of engaging in substantial gainful activity.

I certify that, in my best professional judgment, the student identified above is _____/ is not _____ capable of engaging in substantial gainful activity.

I understand that a student who is currently able or who is expected to be able to work and earn money in *any* capacity in *any* field of work, even on a limited basis, does not have a total and permanent disability as determined by the U.S. Department of Education.

_____ _____
Physician's Signature (a signature stamp is not acceptable) Date (mm-dd-yyyy)

_____
Printed Name of Physician (first name, middle initial, last name)

_____
Street Address

_____
City, State, Zip

_____ _____ _____
Telephone Fax Email Address (optional)

WARNING: *Any person who knowingly and willingly makes a false statement or misrepresentation on this form or on any accompanying document is subject to penalties that may include fines, imprisonment, or both, under the U. S. Criminal Code and 20 U.S.C 1097.*