Santa Clara University

## 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 Santa Clara University. 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 the Physician:*

- Complete this form only if you are a doctor of medicine or osteopathy legally authorized to practice in a state (see definition below).
- 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 certify that, in my best professional judgment, the student identified above is / is not capable of engaging in substantial gainful activity. 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 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.
- I am a doctor of (check one) medicine____ /osteopathic medicine____ in the State of _____. My professional license number is_____.

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 Telephone

_____ _____

City, State, Zip

_____

Financial Aid Office
500 El Camino Real, Santa Clara, California 95053-0609
408-551-1000 FAX 408-554-2154