UNIVERSITY OF BALTIMORE
Office of Financial Aid

2025–2026 Total and Permanent Disability Borrower Acknowledgement and Physicians Certification

Student's Name _____ **Student ID Number** _____
(Student ID begins with 1 or 3)

Instructions and Definitions of Total and Permanent Disability (TPD):

The U.S. Department of Education records identified you, the student, as having at least one federal education loan discharged due to a total and permanent disability. To receive additional loans, this form must be completed and submitted to the Office of Financial Aid and Scholarships for further review.

The U.S. Department of Education (ED) defines total and permanent disability as a condition in which the borrower is unable to work, earn wages, or attend school because of an injury and/or illness which is expected to continue indefinitely or result in death. This form is used for students who have previously had a educational loan discharged but wish to return to school and borrow additional loan funds.

In this case, ED needs confirmation ensuring if the student borrows again, they are able to successfully repay those funds. The student must obtain a Physician Certification (Physician MD, or Doctor of Osteopathy DO) indicating they are able to engage in substantial gainful activity. For the purposes of this certification, "substantial gainful activity" is defined as a level of work performed for pay and/or profit which involves doing significant physical and/or mental activities.

Borrower Acknowledgement and Student Certification

Please review and initial you agree to each statement as part of the borrower acknowledgement statement.

_____I understand I am required to sign a borrower acknowledgement statement each academic year in which I pursue student loans while attending the University of Baltimore.

_____I acknowledge I currently have the ability to engage in substantial gainful activity, which is defined as a level of work performed for pay and/or profit which involves doing significant physical and/or mental activities.

_____I acknowledge any loans I may receive here after **cannot** be discharged in the future based on any present impairment and/or condition, unless the definition of total and permanent disability is met.

_____I understand my prior debt, which has been discharged, **may** be reinstated if this certification is approved and I subsequently borrow another federal student loan. (This is determined by the Department of Education).

_____By signing this document, I certify the information is complete, true, and accurate. I understand purposely providing false or misleading information could result in criminal prosecution, a prison sentence, and/or a fine pursuant to the U.S. Criminal Code.

_____

Student Signature **Date**

Certifying Physician (MD or DO) Must Read and Complete the Following:

The physician must assess the impact of the student's disability against the ability to earn income in light of what the student would normally be able to earn without the disability and/or illness (this calls for a judgment decision as to the ability to earn income despite the disability).

If the disability continues to have significant impact on the earning potential, the ability to repay

the debt, and is expected to last for a long and indefinite amount of time, then the student shall be considered permanently disabled under this definition. However, if the student's condition has improved (since the time their prior loans were discharged) and the student is able to participate in school and substantial gainful activity, a reaffirmation can potentially be processed to allow the borrower to complete the process for regaining eligibility of Federal Title IV student aid, including student loans.

Check one:

[ ] I certify in my professional medical judgment, the patient/student named above is able to engage in substantial gainful activity and attend school

- Date student became able to engage in substantial gainful activity: _____

[ ] I certify in my professional medical judgment, the patient/student named above is not able to engage in substantial gainful activity and attend school.

Physician Information:

I am legally authorized to practice in the name of state: _____

Full Address: _____

Phone number: _____

Printed Name of Physician (MD), or Doctor of Osteopathy (DO): _____

Signature of Physician: _____

Date: _____

Medical License Number: _____