PHYSICIAN'S CERTIFICATION OF BORROWER'S CONDITION
(This form is to be completed ONLY if the patient's condition HAS improved.)

Borrower Name: _____ **SSN:** _____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

I, _____ certify that in my best professional judgment, the condition of
Physician's Name (M.D. or D.O.)

my patient, _____ has improved substantially and can now engage in
Name of Patient

"substantial gainful activity." Substantial gainful activity is defined as the ability to work and earn

money.

Certified on this _____ day of_____. _____
Month and Year **Physician Original Signature (no stamps)**

Type or print the name, address, and telephone number of the physician in the space below:

TO BE COMPLETED BY THE PATIENT

I, _____, acknowledge that any new FFELP or Direct loan guaranteed on my
Name of Patient
behalf after the date of this document may not be discharged due to the same or any disability existing at the time when my new loan is made unless that condition substantially deteriorates to the extent that the definition of total and permanent disability is met.

_____
BORROWER'S SIGNATURE **DATE**

This original form must be **completed by both Physician and Patient** and returned to the following address:

Oklahoma College Assistance Program
Policy and Compliance Services Division
PO Box 3000
Oklahoma City, OK 73101-3000
(800) 247-0420 ¤ (405) 234-4296 ¤ fax (405) 234-4459