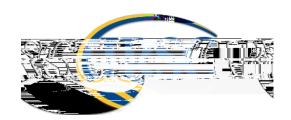
Indian River State College Office of Student Financial Aid 2024 – 2025 Academic Year



Physician's Certification

Student Name:	Student ID Number:
The purpose of this form is for activity and to have borrower a certification cannot be canceled deteriorates to the extent that the second of the content of the extent that the second of the second o	s completed the FAFSA to apply for Federal Student Aid for the 20225 academic school year. The licensed physician to certify that the student borrower is able to engage in substantial fugain cknowledge that any federal loans and/or Teach Grant, received as a result of this physician based on any present impairment or condition, unless that impairment or condition substantial e definition of total or permanent disability is met. This form will allow the borrowes down the following Federal Loan Programs: Federal Direct Student Loans Plus for Teach Grant.

PrivacyActNotice: The PrivacyAct of 1974 (5 U.S.C522A) required that an agencyprovide the following notice to each individual whom it asks to supply information.

- x Theauthority for collecting the information requested on this form is found in 20 U.S.C.1087, 42 U.S.C.209 4k and 22 U.S. C. 2601.
- x Theprincipal purpose of this information is to verify the identity of the borrower; determine that the borrower is able to engage in substantial gainful activity; and in the event it is necessary, to locate the borrower's certifying physician.
- x The routine uses of this information include its disclosure to Federal, State, or local agencies, to guaranty agencies, to education and financial institutions, and to agency contractors for the purpose of verifying the identity of the borrower and the borrower's physician; determining that the borrower is able to engage substantial gainful activity; investigating possible frauth dverifyingcompliance with program regulations. Failure to provide the requested information may result in denial of the borrower's new loan request.
- x This information is necessary to process requests for new Federal Loan Programs and or Teach Grant.

		igned by the certifying physic	ian only	
•	•		•	
I am legally authorize	zed to practice in the state of	of:		
Address of Practice	: Street Address	City	State/Zip Code	
Email Address:		ŕ	ntact Number:	_
form and the definit		ent Disability (see first page),	ed above, and in accordance with the purposes I certify that the patient/borrower is able to enga	

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