

# **REQUEST FOR TEMPORARY TOTAL DISABILITY DEFERMENT**



## **PART 1 – TO BE COMPLETED BY THE BORROWER**

**To be eligible for temporary total disability, the following must apply:**

- Your loan must have been advanced prior to 7/23/92, AND
- Your physician must certify that you are unable to work or attend school due to an injury or illness; OR
- You are caring for a spouse or dependant who is totally disabled, and requires continuous services.

**Borrower Name** \_\_\_\_\_ **Account #(s)** \_\_\_\_\_

**Address** \_\_\_\_\_

**City, State, Zip Code** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Consent for release of information:** I authorize any physician, hospital, or other institution having records pertaining to the disability for which I am requesting a deferment to make information from such records available to the University of Massachusetts for the purpose of determining my claim for disability.

**Borrower's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## **PART 2 THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY BY THE CERTIFYING PHYSICIAN.**

When did the disabled person's present illness or injury begin? \_\_\_\_\_

Date disabled person became unable to work \_\_\_\_\_

Disabled person is \_\_\_\_\_ Ambulatory \_\_\_\_\_ Bed Confined  
\_\_\_\_\_ Rehabilitation Program \_\_\_\_\_ House Confined

If disabled person is hospitalized or in a rehabilitation program, give the institutions name \_\_\_\_\_

Prognosis: Is the condition static? \_\_\_\_\_ Yes \_\_\_\_\_ No

If No, what optimum improvement can be expected:  
\_\_\_\_\_  
\_\_\_\_\_

Diagnosis of disabled person's present medical condition:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(PLEASE COMPLETE THE REVERSE SIDE)**

## PHYSICIAN CERTIFICATION OF TEMPORARY TOTAL DISABILITY

I certify that in my best professional judgement, \_\_\_\_\_ is unable to engage in any substantial gainful activity because of a medically determinable impairment that is expected to continue until: Month \_\_\_\_\_ Year \_\_\_\_\_.

I am legally authorized to practice in the state of: \_\_\_\_\_

I am affiliated with the following medical institution (if not applicable, please indicate) \_\_\_\_\_

Type or print name and address of physician:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Signature of Physician (MD/OD)

### WARNING: Criminal Penalties

Any person who knowingly and willfully embezzles, misapplies, steals or obtains by fraud, false statement, or forgery, any funds, assets, or property provided or insured under Part IV of the Higher Education Act of 1965, as amended shall be fined not more than \$10,000 or imprisoned for not more than five years, or both; but if the amount so embezzled, misapplied, stolen or obtained by fraud, false statement, or forgery does not exceed \$200, the fine shall be not more than \$1,000 and imprisonment shall not exceed one year, or both.

Return completed form to:

University of Massachusetts  
Student Loan Office  
406B Goodell Building  
140 Hicks Way  
Amherst, MA 01003-9272

For more information, either call us at (413) 545-2377, or visit our web site at <http://www.umass.edu/aco/sl>.

### For office use only:

Approved until \_\_\_\_\_ Next Payment Date \_\_\_\_\_  
Payments Deferred \_\_\_\_\_ Interest Waive \_\_\_\_\_  
Date Letter Sent to UHS \_\_\_\_\_ Date Response Received from UHS \_\_\_\_\_  
Disapproved/Reason: \_\_\_\_\_  
\_\_\_\_\_  
Account Analyst \_\_\_\_\_ Date \_\_\_\_\_