60x30TX
Texas Higher Education Coordinating Board

TOTAL AND PERMANENT DISABILITY CANCELLATION REQUEST
B-ON-TIME LOAN PROGRAM

SECTION I: Borrower Identification

Social Security Number or Account Reference Number: _____

Name: _____

Address: _____

City, State, Zip: _____

Telephone - Home: (_____) _____

I authorize any physician, hospital, or other institution having records about the disability that is the basis for my request for discharge to make information from those records available to the Texas Higher Education Coordinating Board.

_____

Signature of Borrower or Representative **Date**

SECTION 2: Physician's Certification

Instructions for Physician: The borrower identified above is applying for cancellation of his/her student loan obligation(s) based on total and permanent disability. You are being asked to complete this form to certify that the applicant is totally and permanently disabled.

Note: The standard for determining disability for cancellation of the borrower's loan obligation may be different from standards used by another state agency or federal agency (for example, the Social Security Administration). Except in the case of certain veterans, a disability determination by another state or federal agency does not establish the applicant's eligibility for discharge of this loan. For the purposes of the B-On-Time Loan, total and permanent disability means the applicant is **(1)** unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death, that has lasted for a continuous period of not less than 60 months, or that can be expected to last for a continuous period of not less than 60 months, **OR (2)** the applicant is a veteran who has been determined by the Secretary of Veterans Affairs to be **unemployable due to a service-connected disability.**

You may complete and sign this form **only** if you are a **doctor of medicine or osteopathy** legally authorized to practice in the state of _____. Provide all requested information; you may attach additional pages if necessary. Please type or print in dark ink. Sign the certification (**a signature stamp is not acceptable**) only if the borrower's condition meets the definition of Total and Permanent Disability as noted above.

Return the completed form to:
Texas Higher Education Coordinating Board
Student Financial Aid Programs
P.O. Box 12788
Austin, Texas 78711-2788

You can contact our office at:
Tel. (800) 242-3062
Fax (512) 427-6423

Diagnoses of applicant's present medical condition — specify the nature, duration and severity of the applicant's present and future impairments. **Do not use abbreviations or insurance codes:**

_____

_____

_____

I certify that, in my best professional judgment, **the applicant identified above is unable to work and earn money in any capacity in any field because of an injury or illness that is expected to continue indefinitely or result in death.** I understand that any applicant able currently or in the future to work, even on a limited basis, is not considered to have a Total and Permanent Disability.

I am a (check one) ☐ **doctor of medicine (MD) /** ☐ **doctor of osteopathy (DO)** legally authorized to practice in the state of _____ and my professional license number issued by that state is _____

_____ _____ _____

Physician's signature **Physician's Name (printed)** **Date**

_____ _____

Address **City** **State** **Zip** **Telephone**

Revised 5/30/2018