

A Mississippi Forgivable Loan debt may be deferred due to temporary disability. Debt may be cancelled due to total and permanent disability. To qualify for cancellation of a state student loan on the basis of total and permanent disability, the borrower must be 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. A recipient is not considered totally and permanently disabled on the basis of a condition that existed before he/she applied for the loan, unless the recipient's condition has substantially deteriorated since he/she submitted the loan application, so as to render the recipient totally and permanently disabled.

PART I – TO BE COMPLETED BY THE BORROWER (COMPLETE IN INK)

Personal Information:

Last Name	First Name	SSN (XXX-XX-XXXX)
Street Address	City	State
Zip	Date of Birth	Email Address
Home Phone #	Cell Phone #	Work Phone #

I certify that all statements made are true and correct. I also certify that I will immediately notify the Mississippi Institutions of Higher Learning of any changes in my employment status. I authorize any physician, hospital, or other institution having records about the disability that is the basis for my request for cancellation to make information available in order to verify this application.

X _____
 Borrower's Signature Date

X _____
 Signature of Borrower's Legal Representative Date
 (If borrower is unable to sign)

PART II – TO BE COMPLETED BY BORROWER'S ATTENDING PHYSICIAN

Disabling Condition:

 Providing Diagnosis Date of Providing Diagnosis

Present Condition (Check One): Recovered _____ Unchanged _____ Improved _____ Deteriorated _____

Any Occupation

Regular Occupation

Is patient now totally disabled for: YES _____ NO _____ YES _____ NO _____

If NO, when is or was the patient able to work? MM/DD/YY _____ MM/DD/YY _____

Will patient be able to resume work? YES _____ NO _____ YES _____ NO _____

If YES, when? MM/DD/YY _____ MM/DD/YY _____

Physician Name		Physician License #	
Clinic/Hospital		Clinic/Hospital Street Address	
City, State, Zip	Telephone #	Fax #	

I CERTIFY THAT THE INFORMATION STATED ABOVE IS CORRECT.

X _____
 Physician Signature Date

CONTACT:

Email: sfa@mississippi.edu
 Phone: 800.327.2980 (toll-free) or 601.432.6791
 Fax: 601.432.6527

RETURN FORM TO:

Office of Student Financial Aid
 Mississippi Institutions of Higher Learning
 3825 Ridgewood Road
 Jackson, MS 39211

PART III FOR OFFICE USE
 PROCESSED BY: _____ DATE: _____