MEDICAL DEFERMENT APPLICATION
PHYSICIAN'S VERFICIATION

Before completing this application, please refer to your promissory note to see if a medical deferment is offered. If your promissory note does allow for a medical deferment, please complete Section I of this form. Section II must be completed and signed by a qualified physician (M.D. or D.O.) A staff member of the University of San Diego Loan Administration office will contact you with the results of your application.

SECTION I:

Name of Borrower:			**Account Number:**
Address (Number, Street, Apt No.:			**Home Telephone Number:**
Place X here if this is a new address	**City/State/Zip Code:**		**Work Telephone Number:**
E-mail Address:	**Birth Date:**	**Circle One: Borrower / Spouse / Dependent**	

I authorize any physician, hospital, or other institution having records pertaining to the disability, for which the borrower is requesting deferment of student loan payments, to make information from such records available to the United States Department of Education or the holder of the Loan(s), the University of San Diego.

_____ _____

Patient's (Borrower) / Guardian's Signature **Date**

SECTION II :

TO BE COMPLETED AND SIGNED BY QUALIFIED PHYSICIAN (M.D. OR D.O.)

Medical Summary:

A) DIAGNOSIS OF ILLNESS OR INJURY: _____

_____

B) DATE AS TO WHEN ILLNESS / INJURY STARTED: _____

C) PATIENT IS (Circle one): Ambulatory / Bed Confined / House Confined / Hospitalized

D) PROGNOSIS: _____

_____

E) I ANTICIPATE THAT THIS PATIENT WILL RECOVER FROM THIS DISABILITY TO THE EXTENT THAT HE/SHE WILL BE ABLE TO ATTEND SCHOOL OR BE GAINFULLY EMPLOYED. (PLEASE INDICATE DATE): _____

F) PROVIDE INFORMATION THAT WILL HELP IN RENDERING A DECISION: _____

_____

_____

I CERTIFY THAT IN MY BEST PROFESSIONAL JUDGMENT, THE ABOVE NAMED PATIENT IS TEMPORARY TOTALLY DISABLE AS A RESULT OF ILLNESS OR INJURY AND IS UNABLE TO ATTEND SCHOOL OR BE GAINFULLY EMPLOYED.

_____

SIGNATURE OF PHYSICIAN (M.D. OR D.O.) **DATE**

_____ _____ _____

PHYSICIAN'S NAME (Please print or type) **License Number** **Telephone Number**

_____

NAME AND ADDRESS OF PHYSICIAN'S PRACTICE (Street, Suite, City, State & Zip Code)

Updated 4/5/04