Financial Aid and Scholarship Services

# Parent Total and Permanent Discharge – Physician Statement

| Academic Year |
|---|
| 2025-2026 |

## Student information (to be completed by the student)

| Last name | First name | | Middle I. | 10-digit ASU ID |
|---|---|---|---|---|
| **Local street address** | **City** | **State** | **Zip code** | **Daytime phone number** |

## Instructions

1. Student information to be completed by the student/parent.
2. **Section A** to be completed by the parent who is the patient.
3. **Sections B and C** to be completed by the Physician/Physician's office.
4. Physician selects a condition that applies to the parent/patient in **section A**.
   a. **Physician MUST be a MD/DM/DO.**
5. Sign, date, and include pertinent physician information in **Section C**, returning the form to the patient.
6. Parent submits this form and supporting documentation online by uploading to https://tuition.asu.edu/forms/fa-misc-verification/2026, mail to P.O. Box 870412, Tempe, AZ 85287-0412, or in person to any Financial Aid and Scholarship Services locations.

## Section A: Parent/Patient Information

List the parent, who is the patient, to which a physician's statement is needed:

| Parent/Patient First Name | Parent/Patient Last Name | Middle Initial |
|---|---|---|
| | | |

## Section B: Physician Statement (to be completed by the physician)

You are receiving this confirmation letter because _____ is the parent of a student attending
(Patient Name)
Arizona State University and is requesting Federal Student Loans on behalf of their student.

If a borrower (your patient) whose prior loan was discharged due to a total and permanent disability wishes to take out a Federal Direct Loan or wishes to receive a Teacher Education Assistance for College and Higher Education (TEACH) grant, they must obtain a certification from a physician (be a Doctor of Medicine or Osteopathy licensed to practice in the United States) that they, the patient, have the ability to engage in substantial gainful activity.

Per the Social Security Administration, the term "substantial gainful activity" (SGA) is used to describe a level of work activity and earnings. Work is "substantial" if it involves doing significant physical or mental activities or a combination of both. "Gainful" work activity is: Work performed for pay or profit.

I am a doctor of: ☐ Medicine ☐ Osteopathy/Osteopathic Medicine

Please select one of the options below:

☐ Yes, the patient listed above, has the ability to engage in substantial gainful activity.

☐ No, the patient listed above, does not have the ability to engage in substantial gainful activity.

## Section C: Physician Certification and Information

**Certification:** I certify that, in my best professional judgment, the submitted information is true and correct to the best of my knowledge and belief.

| Practice Name | Practice Address |
|---|---|
| **Name of Physician (print)** | **Professional License Number (subject to verification)** |
| **Credential** (Please check one): ☐ **MD** ☐ **DM** ☐ **DO** | |
| **Physician Phone Number** | **Physician Email** |
| **Physician Signature** | **Date** |

If you need assistance with completing this form, please contact our office at 855-278-5080 or tuition.asu.edu/contact-resources.