MILWAUKEE AREA Technical College

2024-2025 LOAN DISCHARGE/DISABILITY: VERIFICATION

STUDENT INFORMATION	DN (Please Print)			
Student's Last Name	Student's First Name	e Middle Initial		Student ID Number
Student's Street Address (Include Apartment Number)				Student's Date of Birth
City	State	Zip C	Code	Email Address
Home Phone Number (Include Area Code)		Ce	Cell Phone Number	
cause of a total and perma plete this form and return it IF YOU ARE NOT INTERE	nent disability. Before you car to the MATC Financial Aid Of STED IN RECEIVING FEDER	n receive ffice. RAL LO	e additional fed ANS FOR THIS	re student loans discharged be- leral student loans, you must com- S ACADEMIC YEAR, SIGN AND FOR ANY GRANTS, THOSE WILL
Student's Signature	Date		misleading in	f you purposely give false or formation on this worksheet, you , be sentenced to jail, or both
LO	AN DISCHARGED DUE T	O DISA	ABILITY VER	IFICATION
	SECTION 1: To be con			
taining to the disability for v U.S. Department of Educat By signing below, you are r later be discharged for any ly disabled. If your prior loa affirming by signing below tion substantially deteriorat	which I had a loan(s) cancelletion or the holder of my loan(s) requesting federal loan funds present impairment unless it in was conditionally discharge that collection will resume on	d to mail s). and you deterior ed and the the con- lischarge	re information are aware that you conditional partitionally dischaped in the future	her institution having records per- from such records available to the it any new Federal Loan cannot but are again totally and permanent- period has not elapsed, you are arged loan and unless your condi- for any impairment present when
	reported in this document is t			curate. I understand that any false, and/or repayment of financial aid.
Student Signature	Date	-	misleading in	f you purposely give false or formation on this worksheet, you , be sentenced to jail, or both

Financial Aid Office: 700 West State Street, Room S115 ■ Milwaukee, WI 53233-1443 ■ Phone: 414-297-6282 ■ Fax: 414-297-6466 matc.edu finaid@matc.edu

SECTION 2: To be completed by PHYSICIAN.

Physician Certification: I certify that my patient, the student identified above, has a disability condition that has improved and the student, in my professional opinion, has 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 understand that I may be contacted by MATC Office of Financial Aid for clarification of this student's status.

i am a doctor of:						
□ Medicine□ Osteopathy/Osteopathic Medicine						
In the State of	·					
Please select one of the options below:						
Yes, the patient listed above, has the ability toNo, the patient listed above, does not have the	o engage in substantial gainful activity. ne ability to engage in substantial gainful activity					
Practice Name	Practice Address					
Name of Physician (print)	Professional License Number					
Physican Phone Number	Physician's Email					
Physician's Signature (a signature stamp is not acceptable)						
Date						

WARNING: If you purposely give false or misleading information on this worksheet, you may be fined, be sentenced to jail, or both