WILMINGTON UNIVERSITY™
STUDENT FINANCIAL SERVICES

Office of Financial Aid
320 N Dupont Highway
New Castle, DE 19720
Fax: (302) 328-8905
Email: Finaid@wilmu.edu

2026-2027 Total and Permanent Disability Certification Form

Student Information:

_____ W00_____
Last Name First M.I. Student I.D.

_____ _____
Address City State Zip code Phone Number

According to the U.S. Department of Education, you have had one or more student loans or grants discharged because of total and permanent disability. This form serves to reestablish your eligibility for Federal Student Loan or TEACH Grant Programs when prior loans or a TEACH Grant service obligation have been discharged due to total and permanent disability. Completion of this form does not guarantee that you will qualify for the Federal Student Loan or TEACH Grant Programs.

COMPLETE IF YOU DO NOT INTEND TO PURSUE YOUR FEDERAL LOAN OR TEACH GRANT ELIGIBILITY

_____No, I am not interested in receiving Federal Loans and/or a TEACH Grant
_____I am not interest in receiving loans, but I am interested in OTHER Federal Grants and/or Federal Work Study.

_____ _____
Student Signature Date

COMPLETE IF YOU WISH TO PURSUE YOUR FEDERAL LOAN OR TEACH GRANT ELIGIBILITY

_____Yes, I am interested in receiving Federal loans and/or a TEACH Grant and have a Physician Certification on file dated within one-year of today.

_____Yes, I am interested in receiving Federal loans and/or a TEACH Grant and will be submitting my Physician Certification to verify my eligibility.

I acknowledge that I have previously received a total and permanent disability discharge either through the Federal Family Education Loan Program, William D. Ford Federal Direct Loan Program, Federal Perkins Loan Program, or TEACH Grant service obligation. By my signature below, I clearly understand that any additional student loans or TEACH Grant service obligation I receive must be repaid in full and cannot be canceled in the future on the basis of any impairment present when the new loan is made unless that impairment substantially deteriorates as determined by my physician.

I acknowledge that if my prior Total and Permanent Disability discharged loan or TEACH Grant service obligation is within the three-year provisional period (this period is not applicable to Veterans who received TPD discharges based on a qualifying disability determination by the VA) allowed for disability cancellation, I am required to resume payment on that loan or TEACH Grant service obligation.

CONSENT FOR RELEASE OF INFORMATION: I authorize any physician, hospital, or other institution having records pertaining to the disability for which I previously received cancellation of my loan(s) or TEACH Grant service obligation to make information from such records available to the Financial Aid Office, the U.S. Department of Education, or to the holder of my loan(s).

_____ _____
Student Signature Date

☐ DO NOT SUBMIT THIS FORM WITHOUT PHYSICIAN'S CERTIFICATION

You must submit a completed Physician's certification (on page 2) by a licensed physician's with a MD (Doctor of Medicine) or DO (Doctor of Osteopathy or Osteopathic Medicine) medical credential. If the certification is incomplete or unclear, you will be asked to resubmit or provide additional documentation.

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2026-2027 PHYSICIAN CERTIFICATION

Physician must be licensed in the U.S. as either Doctor of Medicine (MD) or Doctor of Osteopathy/Osteopathic Medicine (DO)

_____ W00_____
Last Name First M.I. Student I.D.

Physician certification required for Federal Student Loan Programs after a Previous Permanent Disability Discharge

This referenced student,_____, was previously classified as totally and permanently disabled. The
Print Student Name
student is now requesting financial aid through one of the Federal Aid programs. To be considered for eligibility, the U.S. Department of Education requires that a Physician (**MD or DO**) certify that a borrower is once again able to engage in substantial gainful activity. Substantial gainful activity is defined as a level of work performed for pay or profit that involves doing significant physical or mental activities, or a combination of both. Your completion of this certification will fulfill this requirement.

COMPLETE IF CONFIRMING STUDENT'S GAINFUL ACTIVITY

I certify in my best professional judgment that the above-named student is able to engage in substantial gainful activity as defined by the US. Department of Education.

Warning: Any person who knowingly makes a false statement or misrepresentation on this form shall be subject to penalties which may include fines or imprisonment under the United States Criminal Code and **20USC1097**.

_____ _____
Physician Signature Date

COMPLETE IF CONDITION HAS NOT IMPROVED

I certify in my best professional judgment; the condition of the student has not improved enough to allow him or her to engage in substantial gainful activity.

_____ _____
Physician Signature Date

PHYSICIAN CONTACT INFORMATION

Please type or print the following:

Physician Name:_____

Address of Practice:_____

City, State, Zip Code:_____

Office Phone Number:_____

PHYSICIAN MEDICAL CREDENTIALS

Please select one:

____**MD** (Doctor of Medicine) ____**DO** (Doctor of Osteopathy/Osteopathic Medicine)

NOTE: The following medical credentials are not acceptable for completing this form and will not be accepted: Doctor of Podiatric Medicine (DPM or podiatrist), Nurse Practitioner (NP), Physician Assistant (PA), Licensed clinical therapist (CMFT, LIMHP, CPC), a Physician from a foreign country unless they are legally authorized to practice in a state, Clinical Psychologist, and Certified Psychologist at the independent practice level. This certification form must be completed by a Physician holding one of the following medical credentials that is legally authorized to practice in a state: MD or DO.