

[Physician's Name, MD/DO]

[Medical License Number]

[State of Licensure]

[Clinic/Hospital Name]

[Address]

[Phone Number]

[Date]

U.S. Department of Education
TPD Discharge Servicer
P.O. Box 87130
Lincoln, NE 68501-7130

RE: Physician Certification for Total and Permanent Disability Discharge

Patient Name: [Patient's Full Name]

Patient Date of Birth: [MM/DD/YYYY]

Patient SSN (Last 4 digits): [####]

To Whom It May Concern,

I am a physician licensed to practice in the United States. I am currently treating the above-named patient for the following medical condition(s):

[List medical diagnoses]

I certify that the patient is 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; OR
- Has lasted for a continuous period of not less than 60 months; OR
- Can be expected to last for a continuous period of not less than 60 months.

Description of Severity:

[Provide a brief description of how the impairment prevents the patient from working or earning money, including limitations on sitting, standing, walking, or cognitive functions.]

I understand that a person who makes a false statement or misrepresentation on this form is subject to penalties that may include fines or imprisonment under the United States Code.

Sincerely,

[Physician's Signature]

[Physician's Printed Name]