Date: [Date]

To: U.S. Department of Education / [Loan Servicer Name]

Subject: Attending Physician's Statement for Total and Permanent Disability (TPD) Discharge

Patient Name: [Patient Full Name]
Patient Date of Birth: [DOB]
Patient SSN (Last 4 digits): [Last 4 Digits]

To Whom It May Concern,

I am a doctor of [Medicine/Osteopathy] licensed to practice in [State]. I am currently treating the above-named patient for the following medical condition(s):

[List Diagnosis/Conditions]

I am writing to certify that the patient has a medically determinable physical or mental impairment that prevents them from engaging in any substantial gainful activity. This impairment is expected to result in death, 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.

Clinical Basis for Disability:
[Brief description of how the condition limits the patient's ability to work or perform basic activities.]

Physician Information:
Name: [Physician Full Name]
License Number: [License Number]
State of Licensure: [State]
Address: [Clinic/Hospital Address]
Phone: [Phone Number]

I certify that the information provided in this statement is true and correct to the best of my professional knowledge.

Sincerely,

[Signature of Physician]

_____
[Typed Name of Physician]