

[Physician's Letterhead/Clinic Name]  
[Address Line 1]  
[Address Line 2]  
[Phone Number]

[Date]

To the U.S. Department of Education / TPD Discharge Servicer,

**Subject: Diagnostic Confirmation for Total and Permanent Disability Discharge**

Patient Name: [Patient Full Name]  
Date of Birth: [MM/DD/YYYY]  
Social Security Number (Last 4 digits): [XXXX]

I am writing to certify that I am a licensed physician (M.D. or D.O.) currently practicing in [State]. I have examined the patient listed above and have reviewed their medical history regarding their physical or mental impairment.

I have determined 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;
- 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.

**Diagnosis:** [Insert Medical Diagnosis/Condition]

**Summary of Impairment:** [Briefly describe how the condition prevents the patient from working or earning an income].

I certify that in my professional medical opinion, [Patient Name] meets the criteria for Total and Permanent Disability as defined by the U.S. Department of Education regulations.

Sincerely,

[Physician Signature]

[Physician Name, M.D./D.O.]  
[Medical License Number]  
[State of Licensure]