[Clinic Letterhead / Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

[Date]

U.S. Department of Education
Total and Permanent Disability (TPD) Discharge Servicer
P.O. Box 87130
Lincoln, NE 68501-7130

RE: Support for Appeal of TPD Discharge Denial
Patient Name: [Patient Full Name]
Patient Date of Birth: [DOB]
Application ID: [Application ID Number, if known]

To Whom It May Concern,

I am writing this letter on behalf of [Patient Name] to formally support their appeal regarding the denial of a Total and Permanent Disability (TPD) student loan discharge. I have been the treating [Physician/Physician Assistant/Nurse Practitioner] for [Patient Name] since [Date].

I am a doctor of [Medicine/Osteopathy] or a [Nurse Practitioner/Physician Assistant/Psychologist] licensed to practice in [State], and my license number is [License Number].

I have personally reviewed the criteria for TPD discharge. It is my professional medical opinion that [Patient Name] meets the federal definition of total and permanent disability because they have a medically determinable physical or mental impairment that:

- Prevents them from engaging in any substantial gainful activity;
- 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.

Diagnosis and Clinical Findings:
[Patient Name] is currently diagnosed with [Diagnosis]. This condition results in the following functional limitations: [List specific limitations such as inability to stand, cognitive impairment, extreme fatigue, etc.].

Basis for Appeal:
The initial application was denied based on [Reason for Denial, e.g., insufficient clinical detail]. However, clinical evidence shows that the patient's condition is chronic and [Permanent/Degenerative]. [Patient Name] is unable to perform any work in the competitive

labor market due to the severity of these symptoms. Their prognosis for improvement is poor despite ongoing treatment and medication compliance.

Attached please find [List attachments, e.g., recent clinical notes, diagnostic test results, or functional capacity evaluations] which further substantiate this claim.

I certify that the information provided in this letter is true and correct to the best of my knowledge. Please reconsider the discharge of [Patient Name]'s student loans based on this medical evidence.

Sincerely,

[Signature of Medical Professional]
[Printed Name and Title]
[Medical License Number]
[State of Licensure]