2021-22
Eligibility Reinstatement Form for Federal Student Loan Programs after a Previous Total and Permanent Discharge (F2FDIS)

MARQUETTE UNIVERSITY

Marquette Central, Office of Student Financial Aid
P.O. Box 1881
Milwaukee, WI 53201-1881
Email: marquettecentral@marquette.edu
Website: marquette.edu/central
Tel: (414) 288-4000

This form serves to re-establish your eligibility for Federal Student Loan Programs when prior loans have been discharged due to total and permanent disability. Completion of this form does not guarantee that you will qualify for Federal Student Loan Programs.

INSTRUCTIONS: You must submit both the signed Student Acknowledgment and Physician Certification the first time they would like to receive a loan through the Federal Student Loan Programs at Marquette University after a total and permanent disability discharge. If eligibility has been reinstated at Marquette University, you only need to return the Student Acknowledgment Section for each additional loan you receive.

Upload documents using Document Upload found under the Financial Aid tile in CheckMarq. You can also return them in person to Zilber Hall, Suite 121 or mail to Marquette Central, Office of Student Financial aid, P.O. Box 1881, Milwaukee, WI 53201-1881.

NOTE: Due to imaging system requirements, photographs of documents are not acceptable.

STUDENT ACKNOWLEDGEMENT SECTION

Student Legal Name (Print): _____ MUID: _____

I acknowledge that I have previously received a total and permanent disability discharge either through the Federal Family Education Loan (FFEL) Program, Federal Direct Loan Program, Federal Perkins Loan Program, or TEACH Grant Service Program. By my signature below, I acknowledge that I have the ability to engage in substantial gainful activity. And, I clearly understand that any additional federal student loans I receive must be repaid in full and cannot be cancelled in the future based on any present impairment when the new loan is made unless that impairment deteriorates so that I am again totally and permanently disabled as determined by my physician. I also understand that if I borrow a new federal student loan during the post-discharge monitoring period I must also resume payment on the old loan before receipt of the new loan.

Signature. Manually sign with a ballpoint pen.
***Forms with digital/electronic/typed signatures cannot be accepted and will be returned.**

Student's Signature: _____ Date: _____

MARQUETTE UNIVERSITY

PHYSICIAN'S CERTIFICATION

STUDENT CONSENT SECTION

Student Legal Name (Print): _____MUID: _____

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) to make information from such records available to Marquette University, the U.S. Department of Education, or to the holder of my loan(s).

Signature. Manually sign with a ballpoint pen.
***Forms with digital/electronic/typed signatures cannot be accepted and will be returned.**

Student's Signature: _____ Date: _____

PHYSICIAN SECTION

The above referenced borrower was previously classified as totally and permanently disabled and as a result of this condition received a total discharge of his/her federal student loan indebtedness. As stated in the Student Section above, the borrower is now requesting financial aid from one of the federal education loan programs. The U.S. Department of Education requires that a physician certify that a borrower is once again able to engage in substantial gainful activity, i.e., the person is sufficiently recovered to be capable of attending school, successfully completing a program of study, and securing employment in order to repay the loan he/she is seeking. Your completion of this section will fulfill this requirement.

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

Physician's Signature: _____ Date: _____

Please type or print the following:

Physician Name: _____

Address of Practice: _____

_____

City, State, Zip Code: _____

Office Phone Number: (_____) _____