UNIVERSITY OF WASHINGTON / BOX 355870 / SEATTLE WA 98195-5870

Name	Social Security No.
Address (Apt.-Street)	Loan No. (Program & Loan# on Billing Statement)
City State Zip Home Telephone *(Including Area Code)*	**E-mail Address**

Instructions:

The attending physician must complete this affidavit of disability, which must be attached to the borrower's deferment and/or forbearance request form. It is the responsibility of the borrower seeking deferment or forbearance to return both forms properly executed to the address given below (1) when eligibility begins (after expiration of the grace period), and (2) annually thereafter as long as status is claimed (up to 3 years maximum).

Complete all sections and return both completed forms to:

Campus Partners
P.O. Box 2901
Winston-Salem, NC 27102-2901

Telephone: 1-800-334-8609
Web: www.mycampusloan.com

PHYSICIAN'S AFFIDAVIT OF BORROWER'S TEMPORARY TOTAL DISABILITY *(To be completed by attending physician)*

I certify that, in my best professional judgment, my patient _____ is temporarily disabled as a result of illness or injury, and is unable to attend school or be gainfully employed. The nature of this patient's illness is: _____. The patient's temporary total disability began on _____, and I anticipate that this patient will recover from this disability to the extent that s/he will be able either to attend school or be gainfully employed by _____.

PHYSICIAN'S AFFIDAVIT OF SPOUSE OR DEPENDENT'S TEMPORARY TOTAL DISABILITY *(To be completed by attending physician)*

I certify that, in my best professional judgment, my patient _____ is temporarily disabled as a result of illness or injury. This patient is the SPOUSE/DEPENDENT *(circle one)* of _____ *(borrower)*. The nature of this patient's illness is: _____. The patient's temporary total disability began on _____. Due to the above condition, **the borrower** is unable to attend school or to be gainfully employed in order to provide required continuous nursing or other similar care for my patient for a period of at least three months. I anticipate that this patient will recover from this disability to the extent that s/he will no longer require continuous nursing or other similar care by _____.

PHYSICIAN'S CERTIFICATION *(To be completed by attending physician)*

I am legally authorized to practice medicine/osteopathy in the State of _____. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Name of Physician *(please print)*	Physician's Signature
Address *P.O. Box* *Street*	Date
City State Zip	Telephone Number *(including area code)*