CERTIFICATION OF DEFERMENT STATUS: HEALTH PROFESSION LOANS (FEDERAL & INSTITUTIONAL)

Name	Social Security No.
Address (Apt.-Street)	Loan No.
City State Zip Home Telephone *(Including Area Code)*	**E-mail Address**

Return this completed form to:

Campus Partners
PO Box 2901
Winston Salem, NC 27102-2901

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

Instructions:
To claim deferment benefits, a Certification of Deferment Status form must be filed. It is the responsibility of the borrower seeking deferment to return this form properly executed to the above address (1) when the first repayment installment is due; (2) annually thereafter as long as status is claimed; and (3) upon termination of status. The authorized official at the institution where the borrower is pursuing Advanced Professional Training must attest to the validity of the statement before the form will be approved. ***Primary Care Loans:*** The terms of the PCL loan program require that you self-certify your area of primary care medical practice annually.

PART I: Request for Deferment of Repayment - To be completed by borrower

I am pursuing advanced professional training full time:

❒ As a Resident ❒ As an Intern ❒ In Fellowship

I claim deferment of repayment of principal for the period from _____ to _____ for the reason checked above.
Month/Year Month/Year

INTEREST PAYMENT OPTIONS *(check one)**:***

❒ I will pay interest **quarterly** during my APT deferment ❒ I will pay interest **monthly** during my APT deferment

❒ I will pay accrued interest at the end of each APT deferment period (at least **annually**)

❒ I wish to **capitalize** interest that accrues during my APT deferment *(Institutional School of Medicine Loans only)*

Date	Signature of Borrower

PART II: Certification of Status - To be completed by official of institution where borrower is pursuing advanced professional training

I certify that the information stated above is true and correct.

Name of Institution or Service Unit	Name of Certifying Official Title of Certifying Official
Address P.O. Box Street	Signature
City State Zip	Date Phone No. *(Including Area Code)*
Primary Care Loans: **I certify I am practicing primary care medicine as a(n)** ❒ Family physician ❒ Osteopathic general practitioner ❒ General internist ❒ Other: _____ ❒ General pediatrician ❒ Specialist in preventive medicine/public health	**Official Seal or Stamp** *(If not available, please provide letter of certification on official letterhead)*

PART III: Institutional Action - To be completed by University of Washington Student Fiscal Services

Approved: Period of Eligibility	Disapproved: Reason
Signature of Loan Officer	Date

(Rev. 11/2003)