



Student Access Loan Program

AFFIDAVIT OF PHYSICIAN

State of _____ City of _____

Personally appeared before the undersigned officer duly authorized to administer oaths,
_____ who upon being sworn, states as follows:

(Physician's name)

1. I am over the age of majority and am competent to testify regarding the matters contained herein. My testimony is based on my personal knowledge.
2. My name is _____, _____ Medical License Number _____
(Physician's name and title)
3. I am a physician authorized to practice medicine in the State of _____ under a valid license issued by the state's medical review board.
4. I have been practicing medicine for _____ years. I have Board Certification(s) in _____.
5. I am currently employed by _____. I have been employed here for _____ year(s).
6. I have treated _____ since _____, _____, for _____.
7. I have determined that _____ is presently totally and permanently disabled and has been totally disabled since _____, _____.
8. Due to this total and permanent disability, it is my professional opinion that Scholar will be unable to teach or serve on a full-time basis.
9. I understand that the information provided herein will be used by Georgia Student Finance Authority ("Authority") to determine if the Authority has the right to cancel or forgive the Scholar's repayment of the Student Access Loan.

Nathan Deal
GOVERNOR



Georgia Student Finance Commission
Georgia Student Finance Authority
Georgia Higher Education Assistance Corporation
GAcollege411

Tricia P. Chastain
PRESIDENT

Further, affiant saith not.

Executed the sworn to before the undersigned officer, this _____ day of _____, 20____.

Sworn to and subscribed before me this _____ day of _____, 20____.

Notary Public

My Commission expires: _____