

**UNIVERSITY OF WISCONSIN STEVENS POINT
PHYSICIAN'S AFFIDAVIT – TEMPORARY TOTAL DISABILITY**

BORROWER'S NAME:	ACCOUNT NUMBER:
------------------	-----------------

I certify that, in my best professional judgment, the above patient is temporarily totally disabled as a result of illness or injury and is unable to attend school or to be gainfully employed. The nature of this patient's illness is: _____.

The patient's temporary total disability began on _____.

I anticipate that this patient will recover from this disability to the extent that they will be able to either attend school or be gainfully employed by _____.

Physician's Comments:

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.

Signature of Physician (MD or DO)

Date

Print or Type Physician's Name

Physician's Address

Telephone

City, State, and Zip Code

Please return the completed form to: University of Wisconsin Stevens Point
Perkins Loan office 003
2100 Main Street
Stevens Point, WI 54481