



## Physician's Affidavit of Temporary Total Disability

Name	Last Four Digits of SSN# XXX-XX-
Address	
City	Cell Phone (       )
State	
Zip	Home Phone (       )
E-mail Address	

**Instructions:**

The attending physician must complete this affidavit of disability. It is the responsibility of the borrower seeking deferment or forbearance to return this form properly executed to the address above (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).

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

I certify that, in my best professional judgment, my patient \_\_\_\_\_ is temporarily totally disabled as a result of illness or injury, and is unable 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 he or she will be able to be gainfully employed by \_\_\_\_\_.

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

I certify that, in my best professional judgment, my patient \_\_\_\_\_ is temporarily **totally** disabled as a result of illness or injury. The nature of this patient's illness is:

\_\_\_\_\_

This patient is the SPOUSE/DEPENDENT (*circle one*) of \_\_\_\_\_ (*borrower*).

The patient's temporary total disability began on \_\_\_\_\_; due to the above condition, the borrower is unable 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 he or she will no longer require continuous nursing or other similar care by \_\_\_\_\_.

**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	Date
Phone Number (       )	