AlaskAdvantage™ Programs
Alaska Commission on Postsecondary Education
P.O. Box 110505, Juneau, Alaska 99811
(800) 441.2962 or in Juneau 465.2962
TTY (907) 465.3143 · Fax (907) 465.5316
www.AKadvantage.alaska.gov

WWAMI DEFERMENT APPLICATION

INSTRUCTIONS:

1. Provide all information in section I, II, and III.
2. You may qualify to postpone payment while you are engaged in educational, service, or employment activity or due to a medical disability as described below. After reviewing the deferment types in section II, indicate the type requested by placing an "X" in the appropriate box.
3. Present this form to the appropriate official to complete the required certification.
4. Sign and return the application.

I. PERSONAL INFORMATION: Please print or type

Name:	Social Security Number:
Mailing Address:	
Telephone: Home: Work:	Deferment Period Requested: Begin date: End date:

II. DEFERMENT TYPES: Please print or type

☐ **Residency Program:** Employed in a medical education residency program for as long as the person remains in the medical residency program. A residency official must certify participation.

☐ **Service Obligation:** Performing a service obligation imposed by the National Health Services Corps, the Indian Health Service, the Uniformed Services Scholarship Program, or other similar program. A program official must certify service.

☐ **Employment to be Considered for Forgiveness Benefit:** Employed full-time as a physician, in Alaska. Employer must certify employment.

CERTIFICATION: To be completed by agency or program official, NOT the borrower.

I certify that the individual applying for this deferment is engaged in the work/education program selected above for the period of ___/____/___ to ___/____/___.

Name of Certifying Official:	Title or Position Held:
Agency or Organization:	
Mailing Address:	Telephone Number:
Signature of Certifying Official:	Date:

☐ **Temporary Total Disability:** Unable to make payments due to a temporary medical disability.

CERTIFICATION: **This section is to be completed by the borrower's licensed physician, NOT the borrower.**

1. Diagnosis: _____
2. Date illness began or injury occurred: ___/___/___
3. Date patient ceased employment or program of study because of disability: ___/___/___
4. First date that you evaluated this patient: ___/___/___
5. Last date that you evaluated this patient: ___/___/___
6. Is this patient totally disabled: ☐YES ☐NO
7. Will this patient be capable of resuming employment or the program of study with or without reasonable accommodation? ☐YES, when? ___/___/___ ☐NO

Physician Information:

Name:	Telephone Number:	
Mailing Address:		
Medical Field/Degree Information:	Licensing State:	License Number:

I certify that I practice within the medical field covering this disability. **Physician's Signature:**	Date:

III. TERMS AND CONDITIONS: Read and sign below

I certify I am eligible for deferment of repayment and meet the conditions as described. Each deferment type requires annual renewal with certification of qualifying status. Applications for loan(s) in default will be denied. If this application is approved, I understand:

1. My repayment schedule will be amended.
2. If I am currently making payments on a reduced payment schedule, that schedule is herby terminated.
3. Monthly payments due must be made until I have received notification of deferment approval.
4. Interest accrues during deferment periods. This interest may be capitalized when payments resume.
5. When repayment resumes at the end of the deferment period, the minimum monthly payment on my account will be at least $50.00.

I hereby authorize the official relevant to the deferment type I have indicated to release pertinent documentation or records to Commission staff to substantiate the basis for my deferment. This includes medical records in the event I am claiming Temporary Total Disability. I personally certify under penalty of perjury that the foregoing is true.

_____ _____

Signature of Borrower **Date**