

**INDIANA UNIVERSITY**  
**Student Loan Administration**  
P. O. Box 1609  
Bloomington, IN 47402-1609  
812-855-4511  
866-IU LOANS  
FAX 812-855-5848

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Student ID

**INDIANA UNIVERSITY**  
**CERTIFICATION OF DEFERMENT**  
**Primary Care Loan (PCL) Program**

Instructions: You as a borrower of a PCL are responsible for the completion and return of this form to the institution from which you received loans. If you fail to submit this form to your school by the payment due date, your school is required to consider your loan past due, and must take actions to collect as required by program regulations, including the use of collection agents, credit bureaus, and litigation.

To request deferment of repayment on your PCL, this form must be filed with the school which made the loan at each of the following times:

1. when your first repayment installment is due.
2. annually thereafter as long as you are eligible for such deferment, and

Recipients with a primary care service obligation must complete this form annually during residency training to notify the lending institution of their training activities.

A copy of the complete form should be retained for your own record.

Address of Loan Recipient

Home Telephone Number

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PART 1: Signature of Loan Recipient**

I request deferment of repayment of principal and interest on my Primary Care Loan for the period indicated in Part II below.

I further agree to notify the school from which I received assistance immediately upon termination of my status as indicated below.

\_\_\_\_\_  
Signature of Borrower

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
Student ID

## PART 2: Request for Deferment of Repayment - to be completed by borrower.

For Primary Care Loan Borrowers

1. Participates in a 3 year residency program in allopathic or osteopathic family medicine, internal medicine, pediatrics, combined medicine/pediatrics, or preventative medicine approved by the Accreditation Council of Graduate Medical Education (ACGME) or by the American Osteopathic Association (AOA) or in a rotating or primary health care internship and general practice residency program approved by the AOA.
2. Participates in a residency program in General Dentistry.

This is to certify that I am/was pursuing advanced professional training in \_\_\_\_\_ (type of residency training) at \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_.

## PART 3: To be completed by the Institution.

Name of Institution \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

Telephone \_\_\_\_\_ Date \_\_\_\_\_

Signature of Official \_\_\_\_\_ Title \_\_\_\_\_

## PART 4: To be completed by INDIANA UNIVERSITY personnel.

For IU Use:  approved  disapproved by \_\_\_\_\_ date \_\_\_\_\_