Alaska Commission on Postsecondary Education

P.O. Box 110505
Juneau, Alaska 99811-0505
Toll Free: (800) 441-2962 • TDD: (907) 465-3143
In Juneau: (907) 465-2962 • Fax: (907) 465-5316
acpe.alaska.gov

WWAMI Deferment Application

Instructions: Complete sections I, II, III, and IV in their entirety. You may qualify to defer payments while you are engaged in educational, service, or employment activity, or due to a medical disability as described below. After filling out section I and reviewing and marking the requested deferment type in section II, present this form to the appropriate official to complete the required certification (section IV). Sign and return the application to ACPE.

I. Personal Information: Please print or type

SNN or Account Number: _____ Name: _____

Address: _____ City, State, Zip Code: _____

Telephone Number – Primary: _____ Telephone Number – Alternate: _____

Email Address: _____

Indicate the dates for which the deferment is requested: Requested Start: _____ Requested End: _____

II. Deferment Types: Please mark deferment type

	Type	Additional Information
☐ A	**Residency Program**	Participation in a medical education residency program. A *residency official* must certify participation.
☐ B	**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.
☐ C	**Employment to be Considered for Forgiveness Benefit**	Employed full-time as a physician, in Alaska. *Employer or community official*, if self-employed, must certify employment.
☐ D	**Temporary Total Disability**	Unable to make payments due to a temporary medical disability. *Licensed physician* must complete the disability certification section below.

III. Terms and Conditions: To be completed by the borrower (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) that are delinquent or 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.

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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: _____

I understand that electronically signing and submitting this document to ACPE legally binds me in the same manner as if I had signed in a non-electronic form. By electronically signing, you consent to be legally bound by this Agreements terms and conditions. Your further agree that your use of a key pad, mouse, or other device to electronically sign, constitutes your signature (hereafter referred to as "E-Signature"), acceptance and agreement as if actually signed by you in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting agreement between you and ACPE.

IV. 3rd Party Certification: To be completed by certifying official (indicated in above marked deferment type)

Deferment Type A-C Certification

Name of Authorized Certifying Official: _____

Title or Position Held by Authorized Certifying Official: _____

Phone Number: _____ Email Address: _____

Address, City, State and Zip: _____

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

Signature of Certifying Official: _____ Date: _____
(wet signature required)

Deferment Type D Certification (Temporary Total Disability)

Patient Information

1. Patient 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 of Physician: _____ Medical Field/Degree:_____

Licensing State: _____ License Number:_____

Phone Number: _____ Email Address: _____

Address, City, State and Zip: _____

I certify that I practice within the medical field covering this disability.

Signature of Licensed Physician: _____ Date: _____
(wet signature required)