



Internship/Residency Forbearance Request

Federal Family Education Loan Program Stafford, PLUS and Consolidation Loans

Before completing this form, carefully read the entire form.

Once completed, return this form to: Loan Servicing, PO BOX 781, Lewiston, ME 04243-0781

You must have an authorized official complete section 5.

Section 1: Borrower Identification	Please Print Clearly
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Last Name	First Name	Middle Initial	Social Security Number
Street Address			Area Code/Telephone Number (home) ()
City	State	Zip Code	Area Code/Telephone Number (other) ()
E Mail Address (optional)			

Section 2: Eligibility Requirements
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- You must have been accepted into a medical or dental internship/residency program that is a supervised training program and that requires you to hold a Bachelor's Degree before acceptance into the program.
- You must reapply every year if you continue to meet the requirements for an internship/residency forbearance.
- **You must have an authorized official complete section 5.**
- Your medical or dental internship/ residency must either:
 - Be **required** before you may be certified for professional practice or service; or
 - Lead to a degree or certification from an institution of higher education, a hospital, or a health care facility that offers postgraduate training.
- If your medical or dental internship/residency program is required before you may be certified for professional practice for professional practice or service, you must attach to this form a separate statement from your state licensing agency which certifies that your internship/residency, in whole or in part, is required before you may be certified for professional practice or service.

Section 3: Forbearance Request

- **If this forbearance request is approved, I want to (check one):**
 - Temporarily stop making payments OR Make smaller payments of \$ _____ per month
- **I meet the required condition stated below** and request that FISC Loan Servicing grant a forbearance on my loan(s) beginning (MM-DD-YYYY) _____ and ending (MM-DD-YYYY) _____ for a period not to exceed 12 months. At the end of the forbearance, I may apply to renew the forbearance if I meet the required conditions.
- **I am engaged in a MEDICAL or DENTAL INTERNSHIP/RESIDENCY program** that (check one)
 - Must be successfully completed before I may begin professional practice or service (state licensing agency certification required); or
 - Leads to a degree or certificate awarded by an institution of higher education, a hospital, or a health care facility that offers postgraduate training.

Section 4: Borrower Understanding and Certifications

- **I understand** that the following terms and conditions apply to this forbearance request:
 - 1) I will continue to receive billing statements for my current payment amount which I must pay until I am notified by FISC Loan Servicing that my forbearance request has been granted.
 - 2) FISC Loan Servicing will not grant this forbearance request unless this form is completed and any required documentation is provided.
 - 3) If I requested a temporary suspension of payments, I may make interest payments if I choose. If I do not pay the interest that accrues on my loan(s), it will be capitalized at the end of the forbearance period.
 - 4) If I requested a reduced payment forbearance, I will receive a monthly bill for the requested payment amount until the forbearance ends, and any unpaid interest that has accrued during the period will be capitalized at the end of the forbearance period.
- **I certify that:**
 - 1) The information I have provided on this form is true and correct.
 - 2) I will provide additional documentation to FISC Loan Servicing, as required, to support my continued forbearance status.
 - 3) I will notify FISC Loan Servicing immediately when the condition that qualified me for the forbearance ends.
 - 4) I have read, understand, and meet the eligibility requirements of the forbearance for which I have applied.
 - 5) Upon termination of this forbearance, I will repay my loan(s) according to the terms of my promissory note and repayment schedule.

Borrower Signature: _____ **Date:** _____

Section 5: Authorized Official's Certification

I certify, to the best of my knowledge and belief, that: 1) The borrower named above is/was a student engaged in the medical or dental internship/residency program indicated in Section 3 from (MM-DD-YYYY) _____ to (MM-DD-YYYY) _____ and 2) the borrower and the borrower's program meet all the eligibility requirements in Section 2.

Institutions' Name _____ ID # _____

Address _____ City, State, Zip _____

Name and Title of Authorized Official _____ Telephone () _____

Authorized Official's Signature _____ **Date** _____