



**Request for Deferment  
Paul Douglas Teacher Scholarship Program  
Florida Department of Education  
Office of Student Financial Assistance  
325 West Gaines Street, Room 934  
Tallahassee, FL 32399-0400**

**toll-free 1-888-827-2004  
fax 1-850-413-7443**

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Permanent Street Address

\_\_\_\_\_  
City State Zip Code

(\_\_\_\_\_)\_\_\_\_\_  
Home Telephone Number

**Check (✓) here if the above reflects a change in your name, address, or telephone number.**

**SECTION I: TO BE COMPLETED BY SCHOLAR**

I request deferment of repayment for the period \_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_.  
month year month year

**I CERTIFY THAT I AM ELIGIBLE FOR DEFERMENT OF REPAYMENT BECAUSE:**

**Check (✓) only one of the six options below.**

1. \_\_\_\_ I am pursuing a full-time course of study at an institution of higher education as defined in 34 CFR 600.4, and I understand that I must submit an additional request for deferment for each term. **(Section II of this form must be completed by the Registrar.)**
2. \_\_\_\_ I am serving full-time active duty in the Armed Forces of the United States or serving as a member of VISTA or the Peace Corps. I understand that my repayment may be deferred for not more than three years under this provision. I understand that I must re-certify my eligibility for this deferment annually. **(Section II of this form must be completed by a commanding officer or supervisor.)**
3. \_\_\_\_ I am temporarily and totally disabled. I understand that my repayment may be deferred for not more than three years under this provision. In addition, I understand that I will be required to re-certify this condition annually. **(Section II of this form must be completed by a physician.)**
4. \_\_\_\_ I am needed to care for my spouse, child, or parent who is totally disabled. I understand that my repayment may be deferred for not more than 12 months under this provision. **(Section II of this form must be completed by a physician.)**
5. \_\_\_\_ I am unable to find full-time employment. I understand that this is a one-time deferment that will defer repayments for a maximum of 12 months.
6. \_\_\_\_ I am unable to make scheduled payments, and I am seeking and unable to find full-time employment as a teacher in a public or private non-profit preschool, elementary, or secondary school, or education program. I understand that this is a one-time deferment which may defer my repayment up to 27 months and that I must re-certify my eligibility for this deferment every 6 months.

The above information is complete and correct to the best of my knowledge.

\_\_\_\_\_  
Scholar's Signature

\_\_\_\_\_  
Date

PAUL DOUGLAS TEACHER SCHOLARSHIP PROGRAM  
**Request for Deferment**

**SECTION II: TO BE COMPLETED BY CERTIFYING OFFICIAL**

*(Required for deferment options 1-5 above on page one.)*

The borrower's deferment status began on \_\_\_\_/\_\_\_\_/\_\_\_\_ and will end on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
month day year month day year

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

(\_\_\_\_\_)\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address City State Zip Code

I certify that, to the best of my knowledge, the information stated above is true and correct and the borrower is entitled to this deferment.

\_\_\_\_\_  
Signature of Certifying Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Title of Certifying Official (Please Print or Type)

**NOT VALID WITHOUT STAMP OR SEAL**



**PLEASE RETURN THIS COMPLETED FORM TO:**  
Florida Department of Education  
Office of Student Financial Assistance  
325 West Gaines Street, Room 934  
Tallahassee, FL 32399-0400