def/cn _____ to _____

def/cn _____ to _____

sent ltr _____

BOSTON COLLEGE

REQUEST FOR CANCELLATION OF PERKINS LOAN
MEDICAL TECHNICIAN/ALLIED HEALTH PROFESSIONAL

Please note: A medical technician is an allied health professional who is certified, registered, or licensed by the appropriate State agency where he/she provides health care services. An allied health professional is someone who assists, facilitates, or complements the work of physicians and other specialists in the health care system.

Note that not all allied health professionals, even those certified, registered, or licensed by a State agency, meet the Perkins Loan definition of "medical technician." Health professionals in the following areas are not generally considered medical technicians and do not fit the definition: dentist, physician, podiatrist, psychologist, veterinarian.

As a recommendation to see which jobs may qualify for cancellation please refer to explorehealthcareers.org website http://explorehealthcareers.org/en/home or the CAAHEP website http://www.caahep.org/.

Please note: To qualify you must be employed as a full-time Medical Technician or Allied Health Professional.

This form must be filled in completely, and you must include a **copy of an official job description** as well as a **copy of your license to practice in the employer's state**.

PART I - TO BE COMPLETED BY THE BORROWER

Borrower's Name _____ BC Eagle ID or the last four digits of your Social Security Number _____

Home Address _____ City _____ State _____ Zip _____ Telephone Number _____

Job Title _____ Email Address _____

Job Description (Note: You **must** submit an official job description with this application.)

Name of Service Agency (Employer)

Address of Service Agency _____ City _____ State _____ Zip _____ Telephone Number _____

❒ I am including a copy of my official job description (required).

❒ I am requesting deferment. Payment of the Perkins loan will be deferred for 12 months.

I began employment on this date: _____.

❒ I am requesting cancellation for service as a full-time medical technician/allied health professional as certified below for the previous 12 months of full-time service.

Period of service beginning _____ and ending _____.

Month Day Year Month Day Year

▶ Medical technician professionals **must** provide licensing information below and include a copy of the license.

State of Licensure: _____ Type of Licensure: _____

Date License Issued: _____ License Number: _____

❒ I am including a copy of my license (required).

▶ If applying for cancellation for the year just ending, check below if you intend to complete another 12 months of employment with the same employer:

❒ I intend to complete another year of employment with the same employer.

▶ _____

Borrower's Signature Date

PART II - TO BE COMPLETED BY THE EMPLOYER

1) Is the borrower certified, registered, or licensed by the governing agency in the state where he/she provides service?	Yes	No
2) Is the borrower employed as a full-time med tech/allied health professional?	Yes	No
3) Does the borrower assist, facilitate, or complement the work of physicians or other specialists in the health care system?	Yes	No
4) Is the borrower providing health care services directly to patients?	Yes	No

5) What is the borrower's job title?_____

_____

Name of Certifying Official Title

_____

Signature of Certifying Official

_____

Telephone Number Date

Cancellation forms can be mailed or faxed to:
Boston College Office of Student Services, Lyons Hall
140 Commonwealth Avenue, Chestnut Hill, MA 02467
Fax: 617-552-0739