



**LENDER VERIFICATION FORM**  
**(TO BE COMPLETED BY EACH LENDER \*)**  
*Please copy additional forms if necessary*

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I authorize my lender, \_\_\_\_\_, to provide the loan information requested by the Office of Student Financial Services.

I certify that the information supplied on this form is correct.

\_\_\_\_\_  
Applicant Signature Date

**This section to be completed by the lending institution**

\_\_\_\_\_  
Name of applicant Account number

\_\_\_\_\_  
Outstanding principle Outstanding interest

\_\_\_\_\_  
Monthly/quarterly payment Date first payment is/was due

**Monthly payment information is necessary although a loan may be in deferment at the present time. If a repayment schedule has not yet been determined, please provide an estimate of the monthly payment.**

Please indicate payment schedule: \_\_\_\_\_ Monthly \_\_\_\_\_ Quarterly

This loan is: \_\_\_\_\_ Current \_\_\_\_\_ In default \_\_\_\_\_ In deferment

Has this loan ever been in default? \_\_\_\_\_ Yes \_\_\_\_\_ No

If YES, when: \_\_\_\_\_

\_\_\_\_\_  
Name of lender to whom payments will be made Printed name of official

\_\_\_\_\_  
Federal ID number of lender Title of official

\_\_\_\_\_  
Address Signature of official

\_\_\_\_\_  
City State Zip Telephone number

\_\_\_\_\_  
Date

This form must be received by **September 11, 2009** by mail or fax:  
MDC-LARP  
Office of Oral Health  
Maryland Department of Health and Mental Hygiene  
201 W. Preston Street, 3<sup>rd</sup> Floor  
Baltimore, MD 21201  
Fax: (410) 333-7392