



# Maryland

DEPARTMENT OF HEALTH

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

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

Email: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

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### 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 **July 29, 2022** by mail or fax:

MDC-LARP  
Office of Oral Health  
Maryland Department of Health  
201 W. Preston Street, 4<sup>th</sup> Floor  
Baltimore, MD 21201  
Fax: (410) 333-7392