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

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 28, 2023** by mail or fax:

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