University of California Governor's Teacher Scholars Repayable Scholarship

Request for Postponement and/or Cancellation

Please print or type

Name | Social Security No.** | Program and Loan Nos. on billing statement

Address | Check if new address ☐

City State Zip

Day telephone Evening telephone
( ) ( )

University of California campus that granted this loan(s)

You may qualify for the following loan cancellation benefits, according to the terms of your promissory note: FULL-TIME TEACHER in a California public elementary or secondary school designated by the U.S. Secretary of Education as having a high concentration of low-income students, and in which more than 30 percent of the school's enrollment are Title I children, according to the list published annually in the *Federal Register* or designated by the State of California as a low-performing school. A "low-performing school" is a school in the bottom half of the Academic Performance Index rankings established pursuant to California Education Code Section 52056(a). If a school meets the Federal or State criteria at the time you are hired, continued employment at that school qualifies you for this benefit, even if the school improves its rank.

To Request Postponement of Repayment in Anticipation of Cancellation *(please print or type)***:** A request for Postponement of repayment in anticipation of Cancellation should be submitted when you are hired to teach in a qualifying school and at the beginning of each subsequent academic year you teach until your loan is cancelled in full. By providing the following information, your loan repayment will be postponed. Should you fail to submit the corresponding Request for Cancellation upon completion of a full year of teaching at a qualifying school, the postponed payments will become due and payable immediately.

Legal Name of School

County | School District

City State Zip

Borrower's Job Title/Description | Date of Hire (MM/DD/YYYY)

Borrower's Qualifying Employment Period (must be at least one complete academic year)

Beginning (MM/DD/YYYY) and Ending (MM/DD/YYYY)

Declaration: I declare that the information shown above is true and accurate. I that I will notify my UC campus immediately upon any change in my employment status. I understand that if, for any reason, I am unable to complete the year of service for which I have requested postponement, I will begin repayment of my loan immediately.

Borrower's Signature:

To Request Cancellation, the following information must be certified by an official of the School or School District *(please print or type)***:** A request for Cancellation should be submitted when you have completed a full year of teaching in a qualifying school, and at the end of each subsequent academic year you teach until your loan is cancelled in full. Upon submission of a certified cancellation form at the end of each year of service, 25% of the original principal amount plus interest accrued thereon will be cancelled provided all eligibility criteria are met. At the end of four years of certified qualifying teaching service, your loan will have been cancelled in full.

Legal Name of School

Address | School District

City State Zip Phone Number

Borrower's Job Title/Description (attach a copy if necessary) Borrower's Date of Hire (MM/DD/YYYY)

Borrower's Completed Qualifying Employment Period (must be at least one complete academic year)*

Began (MM/DD/YYY) and Ended (MM/DD/YYYY)

Certifying Official's Name and Job Title

Certifications:

I certify that this is a California public elementary or secondary school. Yes ___ No ___
I certify that this borrower was employed full time for a complete academic year during the dates listed above. Yes ___ No ___
I certify that this borrower was employed in the capacity listed above. Yes ___ No ___
I certify that all of the information provided in the Cancellation section of is true and accurate. Yes ___ No ___
I certify that this school meets the criteria described above, e.g. low performing, etc. Yes
*Note: Altered dates must be initialed by the Certifying Official.

Signature of Certifying Official:

Date Signed:

This space is for the Institutional Seal. If not available, provide official letter of certification.

SEAL

**** Privacy Act Notice:**
The social security number you provide will be subject to the Privacy Act of 1974, as amended, will be used to match your Request for Postponement and/or Cancellation to your student loan account(s). Failure to provide your SSN may result in delays in processing your request. Disclosure of your SSN is optional.

Return to: UCSC/Student Business Services
1156 High St.
Santa Cruz, CA 95064

OFFICIAL CERTIFICATION LETTER FOR CANCELLATION BENEFITS

NOTE TO BORROWER: Fill out PART A and sign here to request a deferment of payments for the reason indicated by your employer in Part B,C,D, E or F (whichever applies)

Signature

NOTE TO EMLPOYER: Please complete and sign Part B, C, D, E, or F, as applicable. This form may not be certified more than 30 days before the date of employment.

PART A

EMPLOYEE NAME: SSN:

Last First MI

LEGAL NAME OF AGENCY:

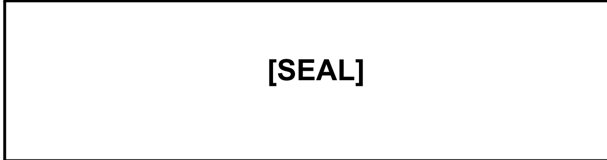
AGENCY ADDRESS: AGENCY PHONE NO: ( )

Street

City State Zip

NAME OF CERTIFYING OFFICIAL:

(please print)



[SEAL]

TITLE:

IF NOT AVAILABLE. PROVIDE A LETTER FROM YOUR EMPLOYER

PART B: NURSE OR MEDICAL TECHNICIAN ***(Federal Register, Vol. 59,* No. *229,* Nov. *30, 1994, Sections 674.51 & 674.56)***

I certify that the above employee is or is expected to be a full-time employee of this institution or facility for twelve consecutive months beginning ____________ and ending ____________ as a: (Please check one or describe similar position in the space provided.)

[ ] Medical Technician: An allied health professional (working in fields such as therapy, dental hygiene, medical technology, or nutrition) who is certified, registered, or licensed by the appropriate state agency in the state in which he or she provides health care services and assists, facilitates, or complements the work of physicians and other specialists in the health care system. (Attach job description.)

[ ] Nurse: A licensed practical nurse, a registered nurse, or other individual who is licensed by the appropriate state agency to provide nursing services.

The employee provides these services in the job capacity of: ____________

Date Received Med Tech/RN License: ____________ or Date Passed State Board: ____________

SIGNATURE OF CERTIFYING OFFICIAL / DATE

PART C: EARLY INTERVENTION SERVICES ***(Federal Register, Vol. 59,* No. *229,* Nov. *30, 1994, Section 674.56)***

YES NO 1. Is this program a public or other non-profit program under public supervision by the lead agency as authorized in section 676(b)(9) or the Individuals with Disabilities Education Act?

YES NO 2. Is your employee (or is your employee expected to be) a full-time employee of this agency for 12 consecutive months? If yes, indicate beginning ____________ and ending ____________ dates.

YES NO 3. Is your employee a qualified professional provider of early intervention services designed to meet a handicapped infant's or toddler's developmental need in any one or more of the following areas: physical development, cognitive development, language and speech development, psycho-social development, or self-help skills (as defined in section 672(2) of the Individual's with Disabilities Education Act)?

YES NO 4. Does your employee provide services to infants and toddlers with disabilities from birth to 2 years old, nclusive? In what job capacity? ____________

(Attach job description)

SIGNATURE OF CERTIFYING OFFICIAL / DATE

Please see other side