

FAMILIES OF FREEDOM SCHOLARSHIP FUND  
Permanent Disability Certification Form

TYPE OR PRINT ALL INFORMATION EXCEPT SIGNATURES

**VICTIM DATA** Last/Family Name \_\_\_\_\_ First/Given \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_ Apt. # \_\_\_\_\_  
City \_\_\_\_\_ State/Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_  
US Social Security Number (if applicable) \_\_\_\_\_  
Place of disability:  World Trade Center  Pentagon  Other \_\_\_\_\_  
Check if applicable:  Firefighter  Police officer  Emergency medical professional  Military  
I am eligible to receive Social Security disability benefits from the United States government due to an injury received as a result of the September 11 attacks.  Yes  No  Pending  
IMPORTANT NOTE: Effective for the 2011/12 academic year and thereafter, victims must provide proof of receiving social security disability benefits each year in order for the dependent(s) to be eligible to receive assistance from the Fund.  
Name of employer on 9/11/2001 \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

**CERTIFICATION** I hereby certify that the information provided on this form is complete and accurate to the best of my knowledge. I understand that if any such information is found to be false, my dependent(s) may be denied assistance.

**DATA PRIVACY/ DISCLOSURE** I authorize any medical doctor, osteopath, hospital, or other institution having records about the disability that is the basis for this certification to make information from these records available to Scholarship America. I authorize Scholarship America to contact the employer named provided to obtain or verify any information requested on this form, and I authorize the employer to provide or verify such information. I understand that a photocopy of this form may be provided to the employer.

I understand that Scholarship America administers the Families of Freedom Scholarship Fund which provides scholarships to persons affected by the September 11 attacks. I authorize Scholarship America to share the information requested on this form with scholarship funders for the purpose of maintaining contact with me and the named Dependent and coordinating any scholarship support that funders may support. I understand that if any such information is to be provided to persons outside of Scholarship America, it will not personally identify me without my permission.

Non-U.S. registrants: Please note that Scholarship America intends to comply with all applicable United States laws regarding the privacy of information you provide to Scholarship America. These laws may provide less protection than the laws of your country.

Signature of Victim or Victim's Representative \_\_\_\_\_ Date \_\_\_\_\_ Printed name of Victim's Representative (if applicable) \_\_\_\_\_ Date \_\_\_\_\_  
Address of Victim's Representative (if applicable) \_\_\_\_\_ Representative's Relationship to Victim (if applicable) \_\_\_\_\_

**MEDICAL CERTIFICATION** This form must be completed in its entirety by the physician or osteopath.

The victim named above is registering his/her dependents to receive assistance from the Families of Freedom Scholarship Fund based on the permanent disability of the victim. Please complete and sign the certification below only if you are a doctor of medicine or osteopathy legally authorized to practice in the United States or other country outside of the United States and if the victim's condition meets the definition of a permanent disability as described below. Provide all requested information and attach additional pages if necessary. Please return the completed form to the victim or victim's representative. Scholarship America may contact you for additional information.

**DEFINITIONS** Permanent disability means the victim is unable to engage in any occupation for remuneration or profit due to a physical or mental impairment which is expected to continue indefinitely. "Physical or mental impairment" is an impairment resulting from an anatomical, physiological or psychological abnormality which is demonstrable by medically acceptable clinical and laboratory diagnostic techniques. NOTE: (1) This definition of permanent disability may be different than standards used under other programs evaluating permanent disability and (2) one cannot be considered to have a permanent disability if the condition existed prior to September 11, 2001, unless the condition has substantially deteriorated as a result of an injury incurred in the impact area.

A physician cannot certify that the victim has a permanent disability if at the time of the physician's certification the victim is able to work and earn money in any capacity or if he expects that the victim will be able to work at any time in the future in any occupation.

Impact area means the secure zone established by the City of New York comprising that area surrounding the World Trade Center which is bordered by Broadway to the East, the Hudson River to the West, Chambers Street to the North and Rector Street to the South; or the crash site of United Airlines flight 93 in Shanksville Pennsylvania on September 11, 2001; or the crash site of American Airlines flight 77 on the grounds of the Pentagon on September 11, 2001.

For those in the impact area, the disability must have occurred after 8:45 a.m. Eastern Standard Time, on September 11, 2001 or between 8:45 a.m. Eastern Standard Time on September 11, 2001 and September 16, 2001 for those firefighters, police officers, emergency medical professionals, and military personnel assisting in the rescue efforts and for those fleeing the site.

I certify that I have read and understand the definitions above.

Physician's Signature (a signature stamp is not acceptable) \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL  
CERTIFICATION**

(continued)

1. Provide an explanation of the victim's present medical condition and explain how it results in a permanent disability. Do not use insurance codes. Attach additional sheets if necessary: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. The victim's medical condition began on (MM/DD/YYYY): \_\_\_\_\_
3. The victim became permanently disabled on (MM/DD/YYYY): \_\_\_\_\_
4. Is the victim's permanent disability a result of the **rescue** activities that occurred during the time between September 11, 2001 and September 16, 2001?  Yes  No  
  
If no, is the victim's permanent disability a result of the victim fleeing the site on September 11, 2001?  Yes  No  
  
Victim must have been in one of the designated impact areas below.
  - a. the area surrounding the World Trade Center bordered by Broadway to the East, the Hudson River to the West, Chambers Street to the North and Rector Street to the South
  - b. at the crash site of United Airlines flight 93 in Shanksville Pennsylvania
  - c. at the crash site of American Airlines flight 77 at the grounds of the Pentagon
5. Does the permanent disability prevent the victim from engaging in any occupation for remuneration or profit?  Yes  No
6. Is the victim's permanent disability expected to continue indefinitely?  Yes  No (If No, complete number 7 below)
7. Is the victim's permanent disability expected to continue for at least 2 years?  Yes  No
8. The victim was last seen by me on (MM/DD/YYYY): \_\_\_\_\_

I certify that in my best professional judgment the victim identified above is unable to engage in any occupation for remuneration or profit because of the permanent disability identified above which is expected to continue as indicated on lines #6 or #7 above. I understand that a victim who is able to work and earn money, even on a limited basis, is not considered to have a severe and permanent disability.

I am a doctor of (check one):  Medicine  Osteopathy

I am legally authorized to practice in the state (or country if outside of the United States) of: \_\_\_\_\_

My professional license number is \_\_\_\_\_ (subject to validation)

\_\_\_\_\_  
Physician's Signature (a signature stamp is not acceptable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Physician

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State/Province, Postal Code

(\_\_\_\_\_) \_\_\_\_\_  
Telephone

(\_\_\_\_\_) \_\_\_\_\_  
Fax

\_\_\_\_\_  
Email address

**Send your form to the following address:**



Families of Freedom Scholarship Fund  
Scholarship America  
One Scholarship Way  
Saint Peter, MN 56082

Please call 877-862-0136 or email [info@familiesoffreedom.org](mailto:info@familiesoffreedom.org) with any questions  
or visit [www.familiesoffreedom.org](http://www.familiesoffreedom.org).