

HEALTH PROFESSIONS STUDENT LOAN APPLICATION

Doctor of Pharmacy Professional Program (Pharm.D.)

PART I: STUDENT INFORMATION

Date: _____ Student ID: _____ Aid Year: _____ Term(s): _____

Student Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel 1: _____ Tel 2: _____ Email: _____

Expected Graduation Date: _____ Requested Amount: _____

PART II: PARENT/SPOUSE INFORMATION

Parent/Guardian 1 Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel 1: _____ Tel 2: _____ Email: _____

Parent/Guardian 2 Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel 1: _____ Tel 2: _____ Email: _____

Spouse Name (if Applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Tel 1: _____ Tel 2: _____ Email: _____

PART III: STUDENT CERTIFICATION & APPROVAL

I have completed the Free Application for Federal Student Aid (FAFSA) for the current year.

I have attached the most recent IRS 1040 Tax Return(s) for my parent(s) and/or spouse.

I will be registered full-time (12+ credits) in the Doctor of Pharmacy Professional Program.

I will use the loan proceeds only for the payment of tuition and required fees; for the purchase of books, instruments and other necessary school supplies and equipment; and for food, lodging, medical care, clothing, and similar items relating to my degree pursuit.

I acknowledge that the information submitted herein is true and correct.

Student Signature: _____

Date: _____

Please email your complete original application with attachments to: bkln-studentsuccess@liu.edu