

FORM OF MEDICAL CERTIFICATE FOR PERSONS WITH DISABILITIES (PWD)

NAME & ADDRESS OF THE INSTITUTE / HOSPITAL

Certificate No. _____

Date: _____

DISABILITY CERTIFICATE

This is certified that Shri/Smt/Kum _____, son/wife/daughter of Shri _____ age _____ sex Male/Female having _____ identification marks as _____ below

is suffering from permanent disability of following category:

A. Locomotor or cerebral palsy:

- | | |
|---|----------------------|
| (i) BL - Both legs affected but not arms. | (a) Impaired reach |
| (ii) BA - Both arms affected | (b) Weakness of grip |
| (iii) OL - One leg affected (right or left) | (a) Impaired reach |
| | (b) Weakness of grip |
| (iv) OA - One arm affected | (c) Ataxic |
| | (a) Impaired reach |
| | (b) Weakness of grip |
| | (c) Ataxic |
| (v) BH - Stiff back and hips (cannot sit or stoop) | |
| (vi) MW - Muscular weakness and limited physical endurance. | |

B. Blindness or Low Vision:

- | | |
|---------------|---------------------------|
| (i) B - Blind | (ii) PB - Partially Blind |
|---------------|---------------------------|

C. Hearing impairment:

- | | |
|--------------|--------------------------|
| (i) D - Deaf | (ii) PD - Partially Deaf |
|--------------|--------------------------|
- (Delete the category whichever is not applicable)*

2. This condition is progressive/non-progressive/likely to improve/not likely to improve. Re-assessment of this case is not recommended. / is recommended after a period of _____ years _____ months.*

3. Percentage of disability in his/her case is percent.

4. Sh./Smt./Kum.....meets the following physical requirement for discharge of his/her duties:-

- | | |
|--|--|
| (i) F - can perform work by manipulating with fingers. | Yes <input type="checkbox"/> / No <input type="checkbox"/> |
| (ii) PP - can perform work by pulling and pushing. | Yes <input type="checkbox"/> / No <input type="checkbox"/> |
| (iii) L - can perform work by lifting. | Yes <input type="checkbox"/> / No <input type="checkbox"/> |
| (iv) KC -can perform work by kneeling and crouching. | Yes <input type="checkbox"/> / No <input type="checkbox"/> |
| (v) B -can perform work by bending. | Yes <input type="checkbox"/> / No <input type="checkbox"/> |
| (vi) S -can perform work by sitting. | Yes <input type="checkbox"/> / No <input type="checkbox"/> |
| (vii) ST -can perform work by standing. | Yes <input type="checkbox"/> / No <input type="checkbox"/> |
| (viii) W -can perform work by walking. | Yes <input type="checkbox"/> / No <input type="checkbox"/> |
| (ix) SE -can perform work by seeing. | Yes <input type="checkbox"/> / No <input type="checkbox"/> |
| (x) H -can perform work by hearing/speaking. | Yes <input type="checkbox"/> / No <input type="checkbox"/> |
| (xi) RW -can perform work by reading and writing. | Yes <input type="checkbox"/> / No <input type="checkbox"/> |

Paste here your recent colour photograph showing the disability.

(The photograph should be attested by the Chairperson of the Medical Board).

Signature of candidate in the above box below the photograph

(Dr. _____)

Registration No. _____

Member, Medical Board

(Signature & Name)

(Dr. _____)

Registration No. _____

Member, Medical Board

(Signature & Name)

(Dr. _____)

Registration No. _____

Member/ Chairperson, Medical Board

(Signature & Name)

(*Please delete words which are not applicable)

Countersigned by the
Medical Superintendent/CMO/Head of Hospital
(with seal)

Note : (i) According to the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Rules, 1996 notified on 31.12.1996 by the Central Government in exercise of the powers conferred by sub-Section (1) and (2) of Section 73 of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1 of 1996), authorities to give disability certificate will be a Medical Board duly constituted by the Central or the State Government. The State Government may constitute a Medical Board consisting of at least three members out of which at least one shall be a specialist in the particular field for assessing locomotor/ hearing and speech disability, mental retardation and leprosy cured, as the case may be.

(ii) The certificate would be valid for a period of 5 years for those whose disability is temporary. For those acquired permanent disability, the validity can be shown as 'permanent'.

Place:
Date :

Seal