

NAME & ADDRESS OF THE INSTITUTE/HOSPITAL

Certificate No. _____

Date _____

DISABILITY CERTIFICATE

Recent Photograph of the candidate showing the disability duly attested by the Chairperson of the Medical Board.

This is certified that Shri/Smt/Kum _____
 Son/wife/daughter of Shri _____ age _____
 Sex _____ identification mark(s) _____ is suffering from
 permanent disability of following category:

A. Locomotor or Cerebral Palsy :

(i)	BL-Both legs affected but not arms	
(ii)	BA-Both arms affected	(a) Impaired reach (b) Weakness of grip
(iii)	BLA-Both legs and both arms affected	
(iv)	OL-One leg affected(right or left)	(a) Impaired reach (b) Weakness of grip (c) Ataxic
(v)	OA-One arm affected	(a) Impaired reach (b) Weakness of grip (c) Ataxic
(vi)	BH-Stiff back and hips (Cannot sit or stoop)	
(vii)	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. Shri/Smt/Kum _____ meets the following physical requirements for discharge of his/her duties:-

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

(Dr. _____)

Member
Medical Board

(Dr. _____)

Member
Medical Board

(Dr. _____)

Chairperson
Medical Board

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

* Strike out which is not applicable.