

FORM OF MEDICAL CERTIFICATE FOR PERSONS WITH DISABILITIES (PWD) NAME & ADDRESS OF THE INSTITUTE/HOSPITAL
DISABILITY CERTIFICATE

Certificate No. _____ Date _____

1. This is to certify that Smt. / Shri / Kum* _____ Son / daughter of _____
 Shri _____ age _____, Male / Female having identification marks _____
 as below _____ is suffering from Permanent disability of _____
 following category.

(Paste here recent
 of passport size
 colour photograph
 of the Applicants
 of size 4 cm x 5 cm)

A. Loco motor or cerebral palsy :

- (i) BL-Both legs affected but not arms.
 (ii) BA-Both arms affected : (a) Impaired reach, (b) Weakness of grip,
 (iii) OL-one leg affected (right or left) : (a) Impaired reach, (b) Weakness of grip, (c) Ataxic
 (iv) OA-One arm affected (right or left) : (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 _____ year _____ months.
3. Percentage of disability in his/her case is _____ Percent.
4. Smt./Shri./Kum* _____ meets the following physical requirement 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 work by reading and writing	Yes	No

(Signature of Doctor)
 Name:
 Registration No.
 Member, Medical Board

(Signature of Doctor)
 Name:
 Registration No.
 Member, Medical Board

(Signature of Doctor)
 Name:
 Registration No.
 Member/Chairperson, Medical Board

*Please delete the words which are not applicable Place:

Date :

Counter signature of 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 whom at least one shall be a specialist in the particular field for assessing locomotors/ 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 who acquired permanent disability, the validity can be shown as permanent.