

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:

BL - Both legs affected but not arms.

BA Both arms affected

- (a) Impaired reach
- (b) Weakness of grip

BLA Both legs and both arms affected

OL One leg affected (right or left)

- (a) Impaired reach
- (b) Weakness of grip
- (c) Ataxic

OA One arm affected

- (a) Impaired reach
- (b) Weakness of grip
- (c) Ataxic

BH Stiff back and hip (Cannot sit or stoop)

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 requirements for discharge of his / her duties:-

- | | |
|--|----------|
| (i) F-can perform work by manipulating with figures. | 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 |

(Dr _____)
Member
Medical Board

(Dr _____)
Member
Medical Board

(Dr _____)
Chairperson
Medical Board

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

* Strike out which is not applicable.