

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

Certificate No. _____
Date: _____

DISABILITY CERTIFICATE

1. This is certified that Smt/Shri/Kum _____
son/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.
 - (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: (C) Hearing Impairment:**
- (i) B- Blind (ii) PB- Partially Blind (i) D- Deaf (ii) PD - Partially Deaf.
- (Delete the category whichever is not applicable)

Paste here your recent colour photograph showing the disability (The photograph should be attested by the chairperson of the Medical Board)
Signature of the candidate

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. Smt./Shri/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"/>

(Signature of Doctor)	(Signature of Doctor)	(Signature of Doctor)
Name:	Name:	Name:
Registration No.:	Registration No.:	Registration No.:
Member Medical Board	Member Medical Board	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 locomotor/hearing & 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.