FORMAT OF THE CERTIFICATE FOR PERSONS WITH DISABILITY

NAME & ADDRESS OF THE INSTITUTE/HOSPITAL ISSUING THE CERTIFICATE

Certificate No.
Date:

CERTIFICATE FOR THE PERSONS WITH DISABILITIES

This is to certify that Shri/Shrimati/Kumari* _____

son/daughter* of _____ Age _____ years,

Registration No. _____ is a case of Locomotor disability/Cerebral Palsy/Blindness/Low vision/Hearing impairment/Other disability* and has been suffering from degree of disability not less than _____ % (_____).

The details of his/her above mentioned disability is described below:

(IN CAPITAL LETTERS) _____

_____

_____

Note:

1. This condition is progressive/non-progressive/likely to improve/not likely to improve.*
2. Re-assessment is not recommended/is recommended after a period of _____ months/years.
3. The certificate is issued as per PWD Act, 1995.

* Strike out which is not applicable.

Sd/-
(DOCTOR)
Seal

Sd/-
(DOCTOR)
Seal

Sd/-
(DOCTOR)
Seal

Signature/Thumb impression of the patient

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

Recent Attested Photograph showing the disability affixed here.