

**FORM OF MEDICAL CERTIFICATE FOR PERSONS WITH DISABILITIES (PWD)**

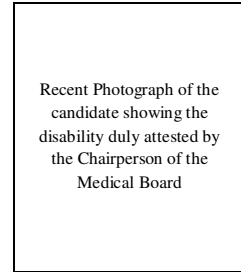
NAME & ADDRESS OF THE INSTITUTE / HOSPITAL:

Certificate No. : .....

Date .....

**DISABILITY CERTIFICATE**

1. 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 (right or left) (a) Impaired reach (b) Weakness of grip (c) Ataxic
- (vi) 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 ..... years ..... Months.\*

3. Percentage of disability in his/her case is ..... percent

4. Shri/Smt./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

(Dr. \_\_\_\_\_)

Member, Medical Board

(Dr. \_\_\_\_\_)

Member, Medical Board

(Dr. \_\_\_\_\_)

Chairperson, Medical Board

Place:

Date:

Counter signed of the  
 Medical Superintendent/CMO/Head of Hospital  
 (with Seal)

\* Strike out the words which are not applicable: