APPENDIX - 6: FORMAT OF THE CERTIFICATE FOR PERSONS WITH DISABILITY

NAME & ADDRESS OF THE INSTITUTE/HOSPITAL ISSUING THE CERTIFICATE

Certificate No.
Date:

CERTIFICATE FOR 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/-	**Sd/-**	**Sd/-**
(DOCTOR)	**(DOCTOR)**	**(DOCTOR)**
Seal	**Seal**	**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.