NAME & ADDRESS OF THE INSTITUTE/HOSPITAL ISSUING THE CERTIFICATE

Certificate No.______________________

Date: ______________________________

CERTIFICATE FOR THE PERSONS WITH DISABILITIES

This is to certify that Shri/Smt./kum____________________________son/wife/daughter of Shri/Smt.__________________________ Age _________________old male/female, Registration No._________________________ is a case of Locomoter Disability/ Cerebral Palsy/ Blindness/ Low vision/ Hearing impairment/ Other disability and has the degree of disability not less than______________% {__________________________ (in words)}.

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

____

____

____

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. This certificate is issued as per the "Persons with Disabilities Act, 1995".

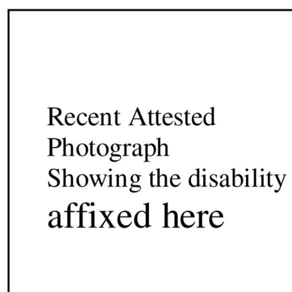
*Strike out which is not applicable.

Sd/-
(DOCTOR)
Seal

Sd/-
(DOCTOR)
Seal

Sd/-
(DOCTOR)
Seal

Signature/Thumb impression
Of the patient


Recent Attested
Photograph
Showing the disability
affixed here

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