

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

NAME &amp; ADDRESS OF THE INSTITUTE/HOSPITAL

DISABILITY CERTIFICATE

Date .....

Certificate No.....

Control No.(for  
office usePaste here recent  
colour passport size  
photograph of the  
SCRIBE of size 4  
cm x 5 cm (The  
colour photograph  
should not be more  
than 3 month old)

1. This is certify that Smt./Shri/Kum \*.....son/daughter of

Shri.....age.....of

Male /Female having identification marks as below

.....is suffering from

Permanent disability of following category.

A. Loco motor or cerebral palsy :

(i) BL-Both legs affected but not arms .

(ii) BA-Both arms affected

(iii) OL-one leg affected (right or left)

(iv) OA-One arms(right or left)

(v) 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-PB-Partially Bind

(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 ..... year .....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	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

(Signature of Doctor)

Name :

Registration No.

Member, Medical Board

\*Please delete the words which are not applicable

Place :

Date :

(Signature of Doctor)

Name:

Registration No.

Member, Medical Board

(Signature of Doctor)

Name:

Registration No.

Member/Chairperson, Medical Board

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 nullified 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 which at least one shall be a specialist in the particular field for assessing locomotor/hearing and 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.