

FORM OF CERTIFICATE TO BE PRODUCED BY PERSON WITH DISABILITY IN SUPPORT OF HIS CLAIM. NAME & ADDRESS OF THE INSTITUTE/HOSPITAL

Certificate No. _____

Date _____

DISABILITY CERTIFICATE

Recent Photograph of
the Candidate showing the
Disability duly attested by the
Chairperson of the
Medical Board.

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
 - (a) Impaired reach
 - (b) Weakness of grip
 - (c) Ataxic
- (vi) BH-Stiff back and hips (Cannot sit or stoop)
- (vii) 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. Sh./Smt./Kum_____meets the following physical requirements 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

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

*Strike out which is not applicable.