

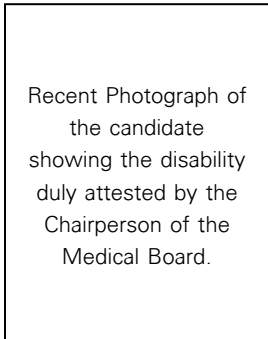
**NAME & ADDRESS OF THE INSTITUTE/HOSPITAL**

Certificate No. \_\_\_\_\_

Date \_\_\_\_\_

**DISABILITY CERTIFICATE**

This is to certify 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 crunching. Yes/No
- (v) B-can perform work by bending. Yes/No
- (vi) B-can perform 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. \_\_\_\_\_) (Dr. \_\_\_\_\_) (Dr. \_\_\_\_\_)  
 Member Member Chairperson  
 Medical Board Medical Board Medical Board

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

**Strike out which is not applicable.**