

Pro forma – F
(For Persons with Disability Candidates)

Name and address of the Institute / Hospital:

Certificate No:

Date:

DISABILITY CERTIFICATE

This is to Certify that Shri/Smt/Ku.....

Son/daughter/wife of Shri.....

Age Sex Identification mark(s).....

Recent
Photograph of the
candidate showing
the disability duly
attested by the
chairperson of the
Medical Board

1. Is suffering from permanent disability of following category

A. Locomotors 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.

Reassessment of this case of not recommended/is recommended after a period ofyearsMonths*.

3. Percentage of disability in his/her case ispercent.

4. Shri./Smt/Ku...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 lifting | 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. _____)
Member/Chairperson Medical Board

*Strike out which is not applicable

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