Annexure-3

FORM OF MEDICAL CERTIFICATE FOR PERSONS WITH DISABILITIES (PWD)
NAME & ADDRESS OF THE INSTITUE/HOSPITAL

Certificate No..... Date:.....

DISABILITY CERTIFICATE

Paste here your recent colour photograph showing the disability.
(The photograph should be attested by the Chairperson of the Medical Board.

Signature of candidate in the above box below the photograph

1. This is certified that Shri/Smt./Kum*.....
Son/Daughter* of Shri.....
age.....sex Male/Female having identification marks as below
.....
is suffering from permanent disability of following category:

A Locomotor or cerebral paisy :
- (i) BL-Both legs affected but not arms.
- (ii) BA-Both arms affected (a) Impaired reach (b) Weakness of grip
- (iii) OL-One leg affected (right or left) (a) Impaired reach (b) Weakness of grip (c) Ataxic
- (iv) OA-One arm affected (right or left) (a) Impaired reach (b) Weakness of grip (c) Ataxic
- (v) BH-Stiff back and hips(cannot sit or stood)
- (vi) 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 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)	(Signature of Doctor)	(Signature of Doctor)
Name:	Name:	Name:
Registration No :	Registration No :	Registration No :
Member, Medical Board	Member, Medical Board	Member/Chairperson, Medical Board

*Please delete the words which are not applicable.

Place :

Date: Countersignature 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 notified 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 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'