ANNEXURE-C

FORMAT OF CERTIFICATE FOR PERSONS WITH DISABILITIES / PHYSICALLY HANDICAPPED CANDIDATES

NAME & ADDRESS OF THE INSTITUTE / HOSPITAL

Certificate No. _____Date_____

DISABILITY CERTIFICATE

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 :-

Affix here recent color Photograph showing the disability duly attested by the chairperson of the Medical Board

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._____) **(Dr._____)** **(Dr._____)**

Member, Medical Board **Member, Medical Board** **Chairperson, Medical Boa**

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

*Strike out which is not applicable.