Annexure-A

Format of the Certificate for the Persons with Disabilities

Name and Address of the Institute / Hospital :

Certificate No. _____

Date : _____

This is to certify that Shri / Smt / Kumari* _____ son / wife / daughter* of _____ Age _____ old male/female, Registration No. _____ is a case of Locomotor Disability / Cerebral Palsy / Blindness / Low Vision / Hearing Impairment / Other disability* and has _____% (_____percent) permanent (physical impairment / visual impairment / speech & hearing impairment) in relation to his/her _____.

Note :-

1. This condition is progressive/non-progressive/likely to improve/not likely to improve.*

2. Re-assessment is not recommended / is recommended after a period of _____ months/years.

* Strike out which is not applicable.

Sd/-	Sd/-	Sd/-
(DOCTOR)	(DOCTOR)	(DOCTOR)
Seal	Seal	Seal

Signature/Thumb impression of the patient

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

Recent Attested Photograph showing the disability affixed here.