NAME & ADDRESS OF THE GOVERNMENT HOSPITAL / INSTITUTE ISSUING THE CERTIFICATE

Certificate No. ____________________________
Date: ____________________________

CERTIFICATE FOR PERSONS WITH DISABILITIES

This is to certify that Shri/Smt./Kum. _________________________________ son/wife/daughter of

Shri/Smt. ____________________________ Age _________________ old male/female, Registration

No. _______________________ is a case of Locomotor Disability / Cerebral Palsy / Blindness /

Low Vision / Hearing Impairment and has the degree of disability not less

than________________% { ______________________________ (in words) }.

The details of his / her above mentioned disability are described below:

____

____

____

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.
3. This certificate is issued as per the "Persons with Disabilities Act, 1995".

* Strike out which is not applicable.

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

Signature / Thumb Impression of the Patient

Recent Attested Photograph Showing the Disability Affixed here

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