

FORMAT OF THE CERTIFICATE FOR PERSONS WITH DISABILITY

NAME & ADDRESS OF THE INSTITUTE/HOSPITAL ISSUING THE CERTIFICATE

Certificate No.

Date:

CERTIFICATE FOR THE PERSONS WITH DISABILITIES

This is to certify that Shri/Shrimati/Kumari* _____
son/daughter* of _____ Age _____ years,
Registration No. _____ is a case of Locomotor disability/Cerebral
Palsy/Blindness/Low vision/Hearing impairment/Other disability* and has been suffering from
degree of disability not less than _____ % (_____).
The details of his/her above mentioned disability is described below:

(IN CAPITAL LETTERS) _____

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. The certificate is issued as per PWD Act, 1995.

* Strike out which is not applicable.

**Sd/-
(DOCTOR)
Seal**

**Sd/-
(DOCTOR)
Seal**

**Sd/-
(DOCTOR)
Seal**

Signature/Thumb impression of the patient

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

Recent Attested Photograph showing the disability affixed here.