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 / Other disability 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/-	Sd/-	Sd/-
(DOCTOR)	(DOCTOR)	(DOCTOR)
Seal	Seal	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)