

## FORM OF MEDICAL CERTIFICATE FOR PERSONS WITH DISABILITIES (PWD)

## NAME &amp; ADDRESS OF THE INSTITUTE / HOSPITAL

Date : .....

## DISABILITY CERTIFICATE

Certificate No.....

1. This is certified that Smt./Shri/Kum\*.....

son/daughter\* of Shri.....

age.....sex Male/Female having identification marks as below  
..... is

suffering from permanent disability of following category :

**A. Locomotor or cerebral palsy :**

- |   |                                 |
|---|---------------------------------|
| (i) BL-Both legs affected but not arms.                   | (a) Impaired reach              |
| (ii) BA-Both arms affected                                | (b) Weakness of grip            |
| (iii) OL-One leg affected (right or left)                 | (a) Impaired reach              |
| (iv) OA-One arm affected (right or left)                  | (b) Weakness of grip (c) Ataxic |
| (v) BH-Stiff back and hips (cannot sit or stoop)          | (a) Impaired reach              |
| (vi) MW-Muscular weakness and limited physical endurance. | (b) Weakness of grip (c) Ataxic |

**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.....year.....months.

3. Percentage of disability in his / her case is.....percent.

4. Smt./Shri/Kum\*..... meets the following physical requirement for discharge of his/her duties :

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| (i) F-can perform work by manipulating with fingers. | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (ii) PP-can perform work by pulling and pushing.     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iii) L-can perform work by lifting.                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (iv) KC-can perform work by kneeling and crouching.  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (v) B-can perform work by bending.                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (vi) S-can perform work by sitting.                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (vii) ST-can perform work by standing.               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (viii) W-can perform work by walking.                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (ix) SE-can perform work by seeing.                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (x) H-can perform work by hearing/speaking.          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (xi) RW-can perform work by reading and writing.     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Paste here your recent colour photograph showing the disability  
(The photograph should be attested by the Chairperson of the Medical Board)

Signature of candidate in the above box below the photograph

**(Signature of Doctor)**

Name :

Registration No. :

Member, Medical Board

**(Signature of Doctor)**

Name :

Registration No. :

Member, Medical Board

**(Signature of Doctor)**

Name :

Registration No. :

Member/Chairperson, Medical Board

\*Please delete the words which are not applicable

Place :

Date :

Counter signature of the Medical Superintendent/CMO/  
Head of Hospital (with seal)

Note : (i) According to the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full participation) Rules, 1996 notified on 31.12.1996 by the Central Government in exercise of the powers conferred by sub-Section (1) and (2) of Section 73 of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1 of 1996), authorities to give disability Certificate will be a Medical Board duly constituted by the Central or the State Government. The State Government may constitute a Medical Board consisting of at least three members out of which at least one shall be a specialist in the particular field for assessing locomotor / hearing and speech disability, mental retardation and leprosy cured, as the case may be.

(ii) The certificate would be valid for a period of 5 years for those whose disability is temporary. For those who acquired permanent disability, the validity can be shown as 'permanent'.