APPENDIX – VI

STANDARD FORMAT OF THE CERTIFICATE

NAME & ADDRESS OF THE INSITIUTE / HOSPITAL ISSUING THE CERTIFICATE

Certificate No. ……. Date …….

CERTIFICATE FOR THE PERSONS WITH DISABILITIES

This is to certify that Shri/Smt./Kum……son/wife/daughter of Shri …….. Age …….old male / female. Registration No. …… is a case of ……. He / She is physically disabled / visual disabled / speech & hearing disabled 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.

Counter signed by the Medical

Superintendent/CMO/

Head of Hospital (with seal)

Recent Attested Photograph showing the disability affixed here