Appendix D:

FORMAT OF THE CERTIFICATE FOR PERSONS WITH DISABILITY (PwD)

Name and address of the Institute/Hospital:

Certificate No.:

Date:

This is to certify that Shri/Smt/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/-	Sd/-	Sd/-
(DOCTOR)	(DOCTOR)	(DOCTOR)
Seal	Seal	Seal

Signature/Thumb impression of the patient

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

Recent Attested Photograph showing the disability affixed here.