FORMAT OF THE CERTIFICATE FOR DIFFERENTLY- ABLED

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 of the applicant)