

### Certificate For Differently Abled

(to be issued by the appropriate notified Medical Authority)

(NAME & ADDRESS OF THE INSTITUTE/HOSPITAL ISSUING THE CERTIFICATE)

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:

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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 \_\_\_\_\_ months/years.
3. This certificate is issued as per the "Persons with Disabilities Act, 1995".

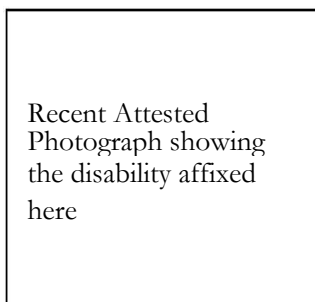
\*Strike out which is not applicable.

Sd/-  
(DOCTOR)  
Seal

Sd/-  
(DOCTOR)  
Seal

Sd/-  
(DOCTOR)  
Seal

Signature/Thumb impression  
Of the patient



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