Annexure VIII

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:

_____

_____

_____

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/-	Sd/-	Sd/-
(DOCTOR)	(DOCTOR)	(DOCTOR)
Seal	Seal	Seal

Signature/Thumb impression
Of the patient

Recent Attested Photograph showing the disability affixed here

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

(The minimum degree of disability in order for a person to be eligible would be 40%.)