

CERTIFICATE FOR THE PERSONS WITH DISABILITIES

NAME & ADDRESS OF THE INSITIUTE / HOSPITAL ISSUING THE CERTIFICATE

Certificate No.

Date

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/-
(DOCTOR)
Seal

Sd/-
(DOCTOR)
Seal

Sd/-
(DOCTOR)
Seal

Signature/thumb impression of
the patient.

Superintendent/CMO/

Resent Attested
Photograph Showing
the disability
affixed here

Counter signed by the
Medical

Head of Hospital (with seal)

ANNEXURE-I

(TO BE FURNISHED BY ALL THE VISUALLY HANDICAPPED CANDIDATES WITH VISUAL DISABILITY OF FORTY PERCENT & ABOVE ALONGWITH THE FILLED UP APPLICATION FORM FOR THE LDC FOR ENGAGING SCRIBE)

REQUISITION FOR ENGAGING SCRIBE BY VISUALLY HANDICAPPED CANDIDATES INCLUDING BLIND AND PARTIALLY BLIND CANDIDATES WITH VISUAL DISABILITY OF FORTY PERCENT AND ABOVE

1. Name in full of the candidate : _____

2. Degree of visual Disability: _____ percent.

3. Whether the assistance of SCRIBE is required for writing the answers in the above examination.:

Write 1 for "Yes" and 2 for "No" in the box

4. Indicate the medium of language for indicating/writing the answers by the Scribe

Medium of Language (Write English or Hindi):

Language Code (Write 1 for English and 2 for Hindi)

5. Centre of Examination : _____

Signature / Right Hand Thumb Impression (RTI) of the Candidate