

## APPENDIX C:

### Format for 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)

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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 of \_\_\_\_\_ months/years.
3. The certificate is issued as per PWD Act, 1995.

\* *Strike out which is not applicable.*

Signature  
(Name of Doctor)

Seal

Signature  
(Name of Doctor)

Seal

Signature  
(Name of Doctor)

Seal

Signature/Thumb impression of the patient:

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

Recent Attested Photograph showing the disability affixed here: