

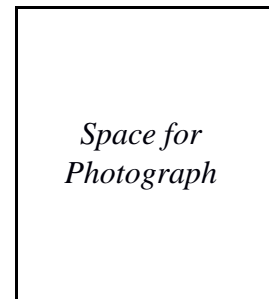
Form (Suggestive)

MEDICAL CERTIFICATE FOR PERSONS WITH DISABILITY (PWD) PARTIALLY DEAF (HI) CANDIDATES

Certified that We, Dr. _____ Dr. _____

And Dr. _____ as the members of District level medical Board have thoroughly examined
Sh.Smt./Kumari _____ Son/Daughter of Shri _____ on
_____ Day
of _____ Year _____ The applicant whose
are given below:

1. Name _____
2. Age _____
3. Sex _____ (Male/Female)
4. Father/Mother/Guardian
Name _____



5. Address: _____

6. Identification Mark _____

7. (a) Nature of disability(HI) _____

(b) Extent of disability _____ (c) Use of Appliances, if
any _____

8. Any other particular to clarify the nature and extent of Disability that the medical Board might like to point
out _____