Appendix-4

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:

Space for Photograph

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_____*