

APPENDIX II

CERTIFICATE FOR PERSONS WITH DISABILITY

No:

Date :

DISABILITY ASSESSMENT BOARD CERTIFICATE

Signature of Candidate : _____

This is to certify that we the members of the Disability Assessment Board at Govt Hospital District examined Sri/Smt. son of /daughter of Aged Years, residing at Village..... Taluk..... District and found that he /she is having Physical disability/Intellectual disability/Mental behaviour/Multiple disabilities/ Disability caused due to The Partial/ Permanent/ Temporary disability is% (in words.....) belonging to MILD/MODERATE/SEVERE/TOTAL category.

We also certify that the above disability adversely affects the normal learning capacity of the individual. Re-assessment is not recommended / is recommended after a period of months/years.

Identification marks :

1 :.....

2.

Note :- This Certificate issued for academic purpose only.

BORAD MEMBERS

Sl. No	Department	Name, Designation & Reg.No	Signature
1	Physiatrist		
2	Orthopaedician		
3	Ophthalmologist		
4	ENT surgeon		
5	Psychiatrist		

MILD : Less than 40%

MODERATE : 40% upto 75%

SEVERE : 75% & above

TOTAL : 100% Profond

Date :

(Office Seal)