

CERTIFICATE OF PHYSICALLY HANDICAPPED CANDIDATE

Despatch No. _____

Dated _____

**TO BE ISSUED BY MEDICAL AUTHORITY OF A
GOVERNMENT HOSPITAL**

1. Name of the candidate _____
2. Father's Name _____
3. Permanent address _____

4. Percentage of loss of earning capacity in words _____
5. Whether the candidate is otherwise able to carry on studies and perform duties _____
6. Name of the disease/cause of handicap _____
7. Whether handicap is temporary or permanent _____
8. Whether handicap is progressive or non-progressive _____

Name of the Certifying Officer
Designation _____

Signature of authorized Medical Officer
(Legible Office Stamp)