National Institute of Health Science & Research

CERTIFICATE OF PHYSICALLY HANDICAPPED CANDIDATE

Dispatch 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

Signature of authorized Medical Officer

(Legible Office Stamp)

Designation ______________________

NIHSR