Medical Examination Form

(The Medical Examination will be conducted by any Govt. Gazatted Officer/Medical Officer at BGJIH)
Items Nos. 1 to 8 below to be filled in by the candidate

Photograph to be attested by Physician

1. Name of the candidate______________________
2. Father's Name____________________________
3. Mother's Name___________________________
4. Date of Birth_____________________________
5. Department (in which admission is being sought)_____________________
6. University Receipt for Medical Examination Fee
   No.__________________ Date__________________ Rs.______________
7. Roll No. (allotted by the Department):
8. History of any previous or existing illness
   I. History of illness like epilepsy, Hypertension, Asthma, Tuberculosis, Rheumatic, Arthritis, Diabetes, Heart Problem etc,
   II. History of any Surgery / Accident
   III. History of any medication ____
   ____

____
(Signature of the candidate to be Attested by the chairman)

____
(Signature of the candidate in the presence of the examining Doctor)

____

(Signature of the chairman with seal of the department)

Medical Examination

A. General Physical Examination
   a) Blood pressure
   b) Pulse
   c) Vision (without glasses) Right ______ left_____
   d) Vision (with glasses) Right ______ left_____
B. Laboratory Test
   Urine : Alb______________________
C. Systemic Examination
D. Any person specific recommendation requiring further tests / examination

It is certified that the above named candidate has been medically examined and found fit to pursue the course of studies to which he or she has already been admitted provisionally.

(Signature of the Medical Officer with seal and date)

FORM OF CERTIFICATE RECOMMENDED FOR LEAVE OR EXTENSION OR COMMUNICATION OF LEAVE AND FOR FITNESS

Signature of patient
Or thumb impression ____________________________

To be filled in by the applicant in the presence of the Government Medical Attendant or Medical Practitioner. (with qualifications-MBBS or above)

Identification marks:-

a. _____________________
b. _____________________

I, Dr. ____________________________ after careful examination of the case certify hereby that _____________________ whose signature is given above is suffering from__________ and I consider that a period of absence from duty of _____________________ with effect from ____________ is absolutely necessary for the restoration of his health.

I, Dr.____ after careful examination of the case certify hereby that _______________________ on restoration of health is now fit of join service.

Signature of Medical attendant
Registration No.___________
(MBBS or above with Mobile #)

Note:- The nature and probable duration of the illness should also be specified. This certificate must be accompanied by a brief resume of the case giving the nature of the illness, its symptoms, causes and duration

COPY OF CERTIFICATE OF PERSONS WITH DISABILITY (PwD) CATEGORY FOR APPLYING FOR ADMISSION

(Detailed information is available at Ministry of Social Justice and Empowerment, Government of India website: www.socialjustice.nic.in as per PART-II Section 3, subsection (i) Notification as amended on 30th December, 2009 for persons with disability (Equal Opportunities and full participation Rules, 1996) (Copies of Form-I, Form-II, Form-III and Form-IV, attached).

Form-I

APPLICATION FOR OBTAINING DISABILITY CERTIFICATE BY PERSONS WITH DISABILITIES

1. Name: (Surname)______________ (First name)________________
   (Middle name) ___________________________
2. Father's name:_________________ Mother's name:___________
3. Date of Birth: (date) _______/ (month) ______ / (year) ___________
4. Age at the time of application: _________ years
5. Sex: _________ Male/Female/Transgender
6. Address:

(a) Permanent address
____
____

(b) Current Address (i.e. for communication)
____
____

(c) Period since when residing at current address
____
____

7. Educational Status (Pl. tick as applicable)
   I. Post Graduate
   II. Graduate
   III. Diploma
   IV. Higher Secondary
   V. High School
   VI. Middle
   VII. Primary
   VIII. Non-literate
8. Occupation ____
9. Identification marks (i)______________ (ii) ___________________
10. Nature of disability: ___________________________________
11. Period since when disabled: From Birth/Since year ______________
12. (i) Did you ever apply for issue of a disability certificate in the past_____YES/NO
    (ii) If yes, details:
    a. Authority to whom and district in which applied
    ____
    b. Result of application
13. Have you ever been issued a disability certificate in the past? If yes, please enclose a true copy.

Declaration: I hereby declare that all particulars stated above are true to the best of my knowledge and belief, and no material information has been concealed or misstated. I further, state that if any inaccuracy is detected in the application, I shall be liable to forfeiture of any benefits derived and other action as per law.

____

(Signature or left thumb impression of person with disability, or of his/her legal guardian in case of persons with mental retardation, autism, cerebral palsy and multiple disabilities)

Date:
Place:
Encl:
1. Proof of residence (Please tick as applicable)
   a. ration card,
   b. voter identity card,
   c. driving license,
   d. bank passbook,
   e. PAN card,
   f. Passport,
   g. Telephone, electricity, water and any other utility bill indicating the address of the Parent / Guardian.

h. A certificate of residence issued by a Panchayat, municipality, cantonment board, any gazette officer, or the concerned Patwari or Head Master of a Govt. school,
i. In case of an inmate of a residential institution for persons with disabilities, destitute, mentally ill, etc., a certificate of residence from the head of such institution.

4. Two recent passport size photographs

(For office use only)

Date:
Place: Signature of issuing authority
Stamp

Form-II

Disability Certificate
(In cases of amputation or complete permanent paralysis of limbs Or dwarfism and in case of blindness)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

Recent PP Size Attested Photograph (showing face only of the person with disability

Certificate No. ________________ Date:__________

This is to certify that I have carefully examined Shri/Smt./Kum.________________________ son/wife/daughter of Shri ____________________ Date of Birth (DD/MM/YY) _____ Age_____ years, male/female, Registration No.______________________ permanent resident of House No.____________ Ward/Village/Street_______________ Post Office_____________, District _________, State_______________, whose photograph is affixed above, and am satisfied that:

(A) He/she is a case of:
- locomotor disability
- dwarfism
- blindness

(Please tick as applicable)

(B) the diagnosis in his/her case is _______________

(C) He/She has ________ % (in figure) ______________ percent (in words) permanent locomotor disability / dwarfism / blindness in relation to his her _____________ (part of body) as per guidelines (…………….. number and date of issue of the guidelines to be specified).

2. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate

Signature /Thumb impression of the person in whose favour disability certificate is issued

Signature and Seal of Authorised Signatory of Notified Medical Authority

Recent PP Size Attested Photograph (showing face only of the person with disability

Form-III
Disability Certificate

(In case of multiple disabilities)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

Certificate No. Date:

This is to certify that we have carefully examined Shri/Smt./Kum.___________________________son/wife/daughter of Shri_______________________ Date of Birth (DD/MM/YY) ______ Age_____ years, male/female, Registration No.__________________________ permanent resident of House No.______________ Ward/Village/Street_________________ Post Office_______________, District _________, State________________, whose photograph is affixed above, and are satisfied that:

(A) He/she is a case of Multiple Disability. His/her extent of permanent physical impairment/disability has been evaluated as per guidelines (………… Number and date of issue of the guidelines to be specified) for the disabilities ticked below, and shown against the relevant disability in the table below:

Sr. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor disability	@		
2.	Muscular Dystrophy			
3.	Leprosy Cured			
4.	Dwarfism			
5.	Cerebral Palsy			
6.	Acid attack Victim			
7.	Low vision	#		
8.	Blindness	**Both Eyes**		
9.	Deaf	**£**		
10.	Hard of Hearing			
11	Speech and language disability			
12	Intellectual disability	**X**		
13	Specific Learning Disability			
14	Autism Spectrum Disability			
15	Mental-illness	**X**		
16	Chronic Neurological conditions			
17	Multiple selerosis			
18	Parkinson's disease			
19	Haemophlia			
20	Thalassemia			
21	Sickle Cell disease			

(B) In the Light of the above, his /her over all permanent physical impairment as per guidelines (………….. number and date of issue of the guidelines to be specified), is as follows

In figures :- ____________________________percent

In words:____ percent

2. This condition is progressive/non-progressive/likely to improve/not likely to improve.
3. Reassessment of disability is:

(i) not necessary.

Or

(ii) is recommended/after__________ years _____________ months, and therefore, this certificate shall be valid till (DD / MM /YY) _________________

@ - e.g. Left/Right/both arms/legs

- e.g. Single eye/both eyes

£ - e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate

5. Signature and seal of the Medical Authority

Nature of Document	Date of Issue	Details of authority issuing certificate

Signature /Thumb impression of the person in whose favour disability certificate is issued

Form-IV

Certificate of Disability
(In cases other than those mentioned in Forms II and III)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

Certificate No. **Date**

This is to certify that I have carefully examined Shri/Smt./Kum.__________________________ son/wife/daughter of Shri______________________ Date of Birth (DD/MM/YY) _____ Age ____ years, male/female, Registration No.________________________ permanentresident of House No.____ Ward/Village/Street________________ Post Office_____________, District _________, State_______________, whose photograph is affixed above, and am satisfied that he/she is a case of___________________ disability. His/her extent of percentage physical impairment/disability has been evaluated as per guidelines (to be specified) and is shown against the relevant disability in the table below:-

Sr. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor disability	@		
2.	Muscular Dystrophy			
3.	Leprosy Cured			
4.	Cerebral Palsy			
5.	Acid attack Victim			
6.	Low vision	#		
7.	Deaf	**£**		
8.	Hard of Hearing			
9.	Speech and language disability			
10.	Intellectual disability	**X**		
11	Specific Learning Disability			
12	Autism Spectrum Disability			
13	Mental-illness	**X**		
14	Chronic Neurological conditions			
15	Multiple selerosis			
16	Parkinson's disease			
17	Haemophlia			
18	Thalassemia			
19	Sickle Cell disease			

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive/non-progressive/likely to improve/not likely to improve.

3. Reassessment of disability is:
   (i) not necessary.
   Or
   (ii) is recommended/after__________ years _____________ months, and therefore, this certificate shall be valid till (DD / MM /YY) ________________

@ - e.g. Left/Right/both arms/legs
# - e.g. Single eye/both eyes
£ - e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	**Date of Issue**	**Details of authority issuing certificate**

(Authorised Signatory of notified Medical Authority)

(Name and Seal)

Countersigned

{Countersignature and seal of the CMO/Medical Superintendent/Head of Government Hospital, in case the certificate is issued by a medical authority who is not a government servant (with seal)}

Signature /Thumb impression of the person in whose favour disability certificate is issued

Note: 1. "In case this certificate is issued by a medical authority who is not a government servant, it shall be valid only if countersigned by the Chief Medical Officer of the District"

Form-V
(intimation of rejection of Application for Certificate of Disability)

No. ____________________ Dated______________

To

(Name and address of applicant
For Certificate of Disability

Sub: Rejection of Application for Certificate of Disability

Sir/Madam,

Please refer to your application dated ___________ for issue of a Certificate of Disability for the following disability: ____________________________________

2. Pursuant to the above application, you have been examined by the undersigned / Medical Authority on __________, and I regret to inform that, for the reasons mentioned below, it is not possible to issue a Certificate of Disability in your favour:-
(i)
(ii)
(iii)
3. In case you are aggrieved by the rejection of your application, you may represent to ___________, requesting for review of this decision.

Yours faithfully,

(Authorized Signatory of the notified Medical Authority)
(Name and Seal)