FORM -1

Medical.certificate for Visually Impaired (Blind) Candidate

Attested Photograph

Certified that I, Dr.———————————————————————————

Registration No. ———————— Dated ———————— have, examined the candidate whose particulars are given below:

1. Name of Candidate :
2. Sex :
3. Age/Approximate Age :
4. Identification mark :
5. Father's Name :
6. Mother's Name :
6. Extent of residual vision, if any — Right eye / Left eye
7. On set of blindness [Please state whether blindness is from birth or acquired. Indicate the age and cause of blindness.
   [For the purpose of concessions granted to blind candidates, blind are those who suffer from either of the following :

a] Total absence of sight.

b] Visual acquity not exceeding : 6/60 or 20/200 [Snellen] in the better eye with correcting lenses.

c] . Limitation of the field of : vision substanding angle of 20 degrees-or worse]

8. Please state clearly whether the candidate is blind and eligible to get concessions, granted by the M.S.B.S. Board.

Signature of Applicant — [Signature of Ophthalmologist]

Place : — Designation :

Date : — Office Stamp :

School Stamp & signature of Head Master : — Address

School No.

FORM -11

Medical Certificate for the Hearing Impaired (Deaf)

Attested Photograph

Certified that I, Dr. _____

Registration No. _____ Dated _____

has examined the candidate on _____ day of _____ 200

1. Name of Candidate :-
2. Sex :-
3. Age/Approximate age :-
4. Identification mark :-
5. Father's Name :-
6. Mother's Name :-
7. An estimate of the residual hearing, if any and the basis on which this estimate has been arrived at-
   a] Right ear :-
   b] Left ear :-
8. Onset of deafness [Please state whether : deafness is from birth or acquired. Cause of deafness may be indicated]

   [For the purpose of concessions granted to deaf candidate, deaf are those in whom the sense of hearing is non-functional for the ordinary purposes of life. Generally loss of hearing in better ear should be 60 decibels or above at . 500,1000,2000 frequencies which will make residual hearing non-functional]
9. Please state clearly whether the candidate is hearing impaired and eligible to get concession granted by the S.S.C./H.S.C. Board.
10. Please enclose audiogram chart

Signature of Candidate
Place :
Date :

[Signature of ENT specialist
Designation :
Office stamp :

Signature of Head Master
& Stamp:
School No :

Address

FORM - III

Medical Certificate in Respect of an Orthopaedically/ Physically Handicapped and Spastic Candidate

Attested Photograph

For the purpose of concessions granted to orthopaedically/physically handicapped or spastic, the Orthopaedically {Physically} Handicapped or spastic are those who have physical impairment or deformity which causes an interference with the normal functioning of bones, muscles and joints.

Certified that I, Dr..... Registration No.....200

have examined the applicant ..... on ..... day of .....200 whose particulars are given below and that he/she Falls within the above definition.

1	Name of Candidate	
2	Identification Mark"	
3	Sex	
4	Age / Approximate Age	
5	Father's Name	
6	Mother's Name	
7	a) Nature of disability : { Tick relevant from following List } POST - POLIO- PARALYSIS, HEMIPLEGIA , QUADRAPLEGIA, MONOPLEGIA FRACTURE.NERVE PARALYSIS , UPPER EXTREMITY, LOWER EXTREMITY, LIMP, PAINFUL, SHORTENING, DEFORMITY,CONGENITAL, ACQUIRED, ABOVE KNEE ,BELOW KNEE, HIP HEMIPELVECTOMY, SYMES, CHEOi ARTS,WRIST,FINGERS,BELOW ELBOW, ABOVE ELBOW, SHOULDERS TORE; QUARTER, UNILATERAL, BILATERAL b) Extent of disability Estimate in percentage [mc.Bridge Scale]	

ON ANATOMICAL, FUNCTIONAL, [PATIENTS ASSESSMENT .EXAMINER'S ASSESSMENT] Percentage [Please state whether the percentage of disability is 40 or above] c] Use of applicant : [Tick relevant from following list] CALLIPER, CRUTCH, ABOVE KNEE. BELOW KNEE. PROSTHESIS, CANE,UNILATERAL, BILATERAL. ABOVE ELBOW, BELOW ELBOW HEMIPELVECTOMY. SHOULDER- DiS-AP.TICULATION d] Any operation done or indicated c] Photograph [Attested] To show the nature of disability and any applience if used. 7. Any other particulars to clarify that nature and extent cf disability that the Surgeon might like to point out.	

Please state clarly whether the candidate is orthopaedically / physically handicapped / spastic and eligible to get concessions granted by the S.S.C. / H.S.C. Board.

Signature of Applicant
Place. :
Date :

Signature of Orthopadic Surgeon
Designation :
Office stamp :
Address :

School Stamp and signature of Head Master
School No.

FORM IV

Medical Certificate for Candidates Having Learning Disability

Attested Photograph

We certify that Dr./Neurologist
Regd No. and Psychologist
Regd. No. / Licence No. have examined the candidate whose particular's are given below on the following dates independent of each other.

1. NAME OF THE CANDIDATE

2. SEX

3. AGE / APPROXIMATE AGE

4. IDENTIFICATION MARK

5. FATHER'S NAME

6. MOTHER'S NAME

7. NATURE OF THE DISABILITY :- [Based on the tests devised by the board comprising of a neurologist, child psychologist and special educator]
Please indicate the disability with a [✓] [tickmark].

[a] DYSLEXIA : ☐

[b] DYSGRAPHIA : ☐

[c] DYSCALCULIA : ☐

Signature of the examining (neurologist) and Date :
Signature of the examining paediatrician /
Special educator and Date :
Countersigned by Civil Surgeon and Date

Signature with Date & Stamp
(Civil Surgeon/Neurologist/Psychologist)

Medical Certificate for Austistic Candidate

Attested
Photograph

Certified that, I Dr. _____

Registration No. _____ Dated _____ have examined this candidate whose particulars are given below :

1. Name of the Candidate :
2. Sex :
3. Age/Approximate Age
4. Identification Mark :
5. Father's Name :
6. Mother's Name :
7. Extent of autism
8. Please state clearly whether the candidate is autistic and eligible to get concession granted by the S.S.C. Board.

Signature of (Specialized Doctor)
Designation
Office Stamp
Address :

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