

Government of India
DR. RAM MANOHAR LOHIA HOSPITAL
SAFDARJUNG HOSPITAL
ALL INDIA INSTITUTE OF MEDICAL SCEINCES
(Please Strike out whichever is not applicable)

No.

Date

1) **General Observations:**

This is to certify that Ms/Mrs/Mr. _____ aged _____
years,

Male/Female, son /daughter/wife/husband/father/mother/brother/sister/mother or father-
in-law of Ms/Mrs/Mr _____, is a
diagnosed case of _____

and is undergoing treatment in the department of
_____ of this Hospital since
_____.

2) **Specific recommendations:**

- (i) Detailed description of illness/disability alongwith investigations, if any:
- (ii) Is the disability permanent or likely to improve with time.
- (iii) Class/stage of disease/percentage/grade of functional disability inspite of optimum treatment and intervention,
- (iv) Is the ailment/disability serious enough to be considered for allotment or change of Govt. Accommodation at any / Ground Floor on overriding priority:

Signature of patient/Guardian }

Alongwith Attested Photograph}

Note:- Physical disability certificates issued by single doctor in pursuance of Guidelines No. 5-13020/1/2010-MS/MI-I-II of Directorate General of Health Services (Medical Hospital Section-II), Nirman Bhawan, dated 18.6.2010 is also acceptable.

Signatures of Members of Board alongwith rubber-stamp/dale:

(Member)
(Seal with Name)

(Member) (Seal with Name)

(Member) (Seal with Name)

(Medical Superintendent)
(Seal with Name)