MEDICAL CERTIFICTE

1. Name : _____

2. Father's Name : _____ Mother's Name : _____
(without Army No and Rank) (without Army No and Rank)

3. Date of Birth :_____ **4.** Sex : _____

5. Address :-

(a) Permanent address :-

(b) Current address:-

6. Mobile No and E Mail ID of Parents :- _____

7. Nature of disability :- _____

8. Type of disability : Permanent/Temporary.

9. Percentage of disability :- _____

10. Name and address of the hospital/ certifying authority which issued the Certificate of Disability.

11. Validity of existing certificate (date)_____.

12. **Declaration by students/ parents**: -

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 at any stage, I shall be liable to forfeiture of any benefits derived and other action as per law*.

Date : _____ _____

(Signature of Student with name)
Signature of father in case of minor

Station : **(Signature of Medical Officer)**

Dated : **with office seal)**

COUNTERSIGNED

(Chief Medical Officer)

* Note : As indicated in the RPWD Act 2016.