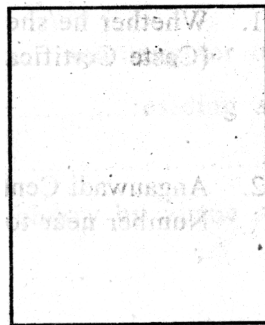


GOVERNMENT OF PONDICHERRY
SOCIAL WELFARE DEPARTMENT

**APPLICATION FOR ISSUE OF MOTORISED TRI-CYCLE
TO PERSONS WITH DISABILITIES**

FORM-I



Name of the Applicant
and Identification Card Number.

2. Name of the Father/Guardian

3. Address for Communication

4. Date of Birth/Age
(Certificate to be enclosed)

Day	Month	Year	Age
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. Sex Male/Female

6. Nationality

7. Details of any other benefits availed:
so far from this Department.

8. Nature of Disability

9. Annual Income

Rs.

10. Details of any other benefits availed/ :
Availing from this Department.

Whether he/she belongs to SC/ST
(Caste Certificate to be enclosed).

12. Anganwadi Centre Name with Code
Number near to your residence.

DECLARATION BY THE APPLICANT/PARENT/GUARDIAN

I, hereby declare that the particulars furnished above are correct and true to the best of my knowledge and that I have not received any financial assistance for conveyance purpose from the Department of Social Welfare or from any other source. I have not suppressed any material information that makes me ineligible to receive this Motorised Tri-cycle. I understand that the sanction to be issued on the strength of the above information is liable to be cancelled if it is found that the information furnished by me is proved to be incorrect and false.

Signature of the Applicant

Signature of the Parent/Guardian.

FORM-II

(To be obtained from the Revenue Department)

NATIONALITY / COMMUNITY / RESIDENCE / INCOME CERTIFICATE

This is to certify that—

(i) hiru/Tmt./Selvi son/daughter of
.....residing at

is a native/resident of the Union Territory of Pondicherry by virtue of his/her birth/continuous residence of not less than five years.

(ii) He/She belongs to Scheduled Caste/Scheduled Tribe Community.

(iii) His/Her (or) His/Her parent's Annual Income is Rs.

Place

*Signature of the Tahsildar/Deputy Tahsildar
with Office Seal*

Date

FORM-III
[See rule 5 (2)]

APPLICATION-CUM-DECLARATION AS TO PHYSICAL FITNESS

Name of the Applicant

2. Son/Wife/Daughter of
 3. Permanent Address
 4. Temporary Address (if any)
 5. Identification Marks (1)
- (2)

DECLARATION

- (a) Do you suffer from epilepsy or from sudden attacks or loss of consciousness or giddiness from any cause? Yes/No
- (b) Are you able to distinguish with each eye (or if you have held a driving licence to drive a motor vehicle for a period of not less than five years and if you have lost, the sight of one eye after the said period of five years and if the application is for driving a light motor vehicle other than a transport vehicle fitted with an outside mirror on the steering wheel side) or with one eye at a distance of 25 metres in good day light (with glasses if worn) a motor car number plate? Yes/No

- c Have you lost either hand or foot or are you suffering from any defect or muscular power of either arm or leg ? Yes/No
- (d) Can you readily distinguish the pigmentary colours, red and green ? Yes/No
- (e) Do you suffer from night blindness ? Yes/No
- (f) Are you so deaf as to be unable to hear (and if application is for Driving a Light Motor Vehicle, with or without hearing aid) the ordinary sound signal ? Yes/No
- (g) Do you suffer from any other disease or disability likely to cause your driving of a motor vehicle to be a source of danger to the people if so give details. Yes/No

I hereby declare that to the best of my knowledge and belief, the particulars above the declaration made therein are true.

Signature or Thumb-impression of the Applicant

Note : (1) An applicant who answers 'Yes' to any of the questions (a), (c), (e), (f) and (g) or 'No' to either of the questions (b) and (d) should amplify his answers with full particulars and may be required to give further information relating thereto.

(2) This declaration is to be submitted invariably with Medical Certificate in Form-III A.

FORM-III A

[See rules 5 (1) (3), 7, 10 (a), 14 (d) and 19 (d)]

MEDICAL CERTIFICATE

[To be filled in by a registered Medical Practitioner appointed for the purpose by the State Government or person authorised in this behalf by the State Government referred to under sub-section (3) of section (8)]

Name of the Applicant

2. Identification Marks (1)
- (2)
3. (a) Does the applicant to the best of your judgement : Yes/No
suffer from any defect of vision? If so, has
it been corrected by suitable spectacle.
- (b) Can the applicant to the best of your Judgement Yes/No
readily distinguish the pigmentary colours,
red and green?
- (c) In your opinion is he able to distinguish with Yes/No
his eye sight at a distance of 25 meters in
good day light a motor car number plate ?
- (d) In your opinion does the applicant suffer Yes/No
from a degree of deafness which would prevent
his hearing the ordinary sound signals?
- (e) In your opinion does the applicant suffer : Yes/No
from night blindness?
- (f) Has the applicant any defect or deformity Yes/No
or loss of member which would interfere
with the efficient performance of his duties
as a driver ?
- (g) , If so, give your reasons in details

-
- OPTIONAL : (a) Blood Group of the applicant (If the applicant so desires that the information may be noted in his driving licence).
- (b) RH factor of the applicant (If the applicant so desires that the information may be given in his driving licence).

DECLARATION

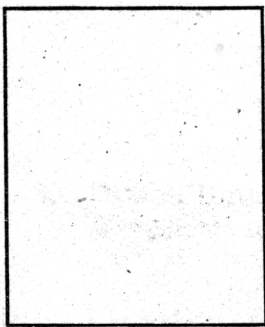
Made by the applicant in Form-I as to his Physical Fitness is attached trans

I certify that I have personally examined the applicant
I also certify that while examining the applicant. I have directed special attention to the distance vision and hearing ability, the condition of the arms, legs, hands and joints of both extremities of the candidate and to best of my judgement, he is medically fit/not fit to hold a driving.licence..

The applicant is not medically fit to hold a licence for the following reasons

Signature

- 1 Name and Designation of the :
Medical Officer/Practitioner.



(Seal)

- 2. Registration Number of the
Medical Officer.
- 3. Signature or Thumb-impression:
of the Candidate.

Date

Note : The Medical Officer shall affix his signature over the photograph affixed in a manner that part of his signature is upon the photograph and part on the certificate.