MEDICAL CERTIFICATE FOR THE BLIND

Issued under authority vide G.O.ms.No.109, Women Development child Welfare and Labour Department Dated 15.6.1992.

Certified that District Medical Board _____ have this _____ day of _____ 20 _____

Examined the candidate whose particulars are given below:

1. Name of Candidate :
2. Father's Name :
3. Sex ;
4. Approximate Age :
5. Identification Marks :
6. Extent of Residual Vision, if any
   1. Right Eye
   2. Left Eye
7. Onset of blindness (Please state whether blindness is from birth or acquired, later if it has been caused afterwards, the ager and cause of blindness may be indicated.

   (For all the purposes of assistance, the blind are those who suffer from either of the following)
   a) Total Absence of sight
   b) Visual acquity not exceedings 6/60 of 20/200 (Snellen) in the better eye with correcting lenses
   c) Limitation of the field of vision substanding an angle 20 degrees of worse.
8. Please state clearly whether the candidature is blind for all purpose of assistance.
9. specify whether the candidate is totally blind for partially blind.

SIGNATURE OF APPLICANT Signature of Medical