Form NO:- II

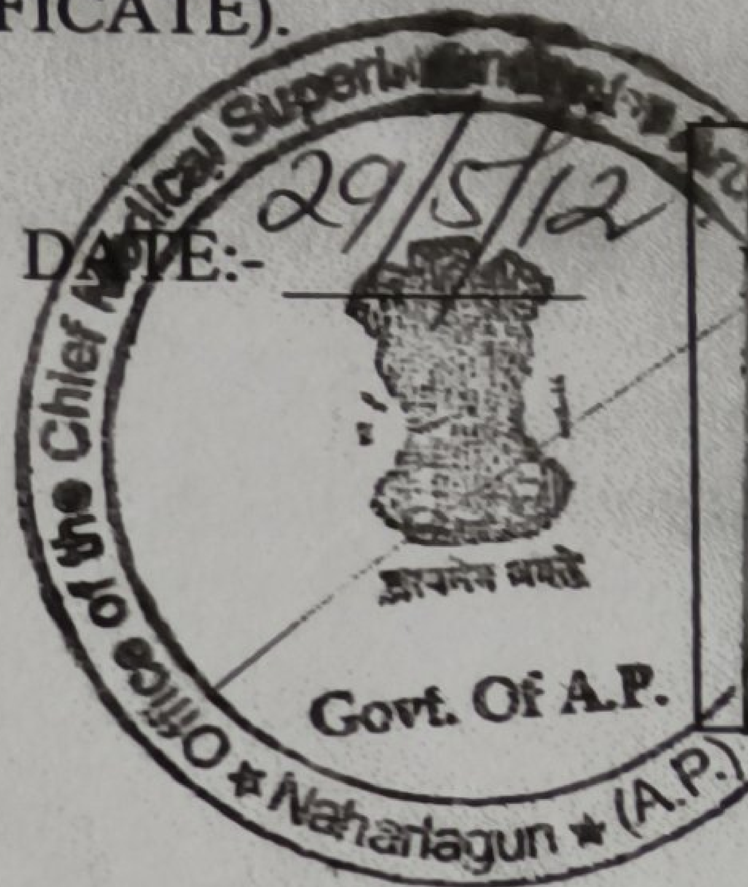
Disability Certificate

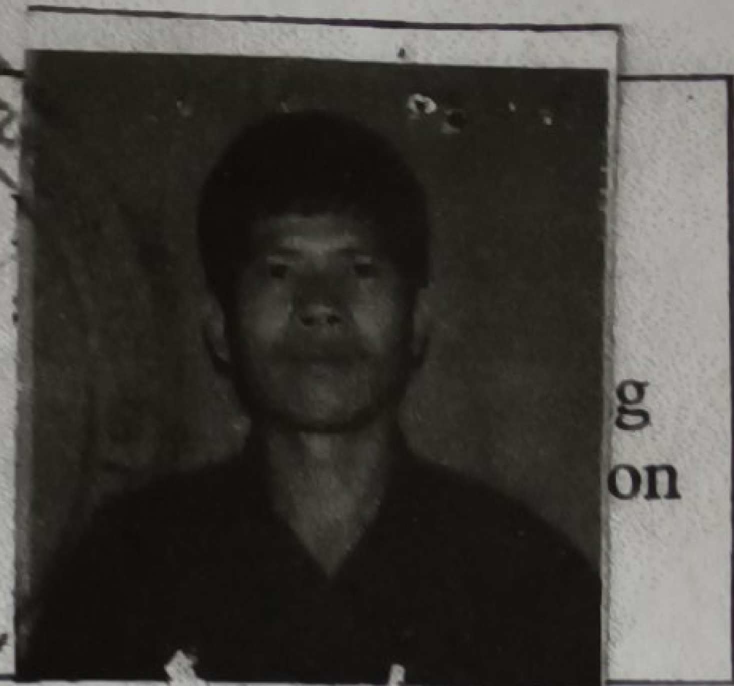
(In cases of amputation or complete permanent paralysis of limbs and in cases of blindness)

(See rule 4)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE).

CERTIFICATE NO:- 69/2012. DATE:- 29/5/12





This is to certify that I have carefully examined Shri/~~Smti~~

/~~Kumari~~ Khyoda Tagum son/~~wife/daughter~~ of

Shri/~~Late~~:- Khyoda TAKO.

Date of Birth 01-03-1970 Age 40 years.
(DD)/MM/YY

Male/~~Female~~. Male.

Registration NO:- ____ permanent resident of House NO:- ____

~~Ward~~/Village/ ~~Street~~ Pania Post Office:- Pali

District :- Kurung Kumey State:- (A.P.)

Whose photograph is affixed above, and am satisfied that;-

(A) he/~~she~~ is a case of :-

- Locomotor disability ✓
- Blindness

(Please tick as applicable)

(B) The diagnosis is his/~~her~~ case is !PPRP(L)LL

DA
Pile in 8/B

C/S

Lo 30/5

(Dr. D. Raina)
Medical Superintendent
Arunachal State Hospital
Naharlagun

Receipt No. 181
Date 11/07/012
Office of the Dy Dir... School Education
Kurung Kumey Dist (A.P.)

Gdh
12/7/12

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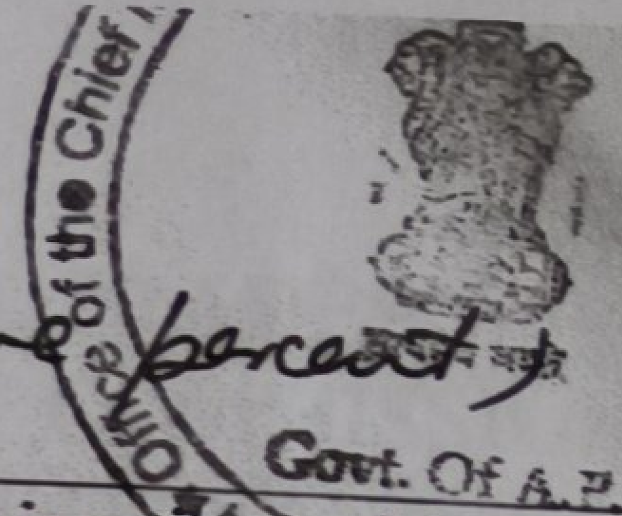
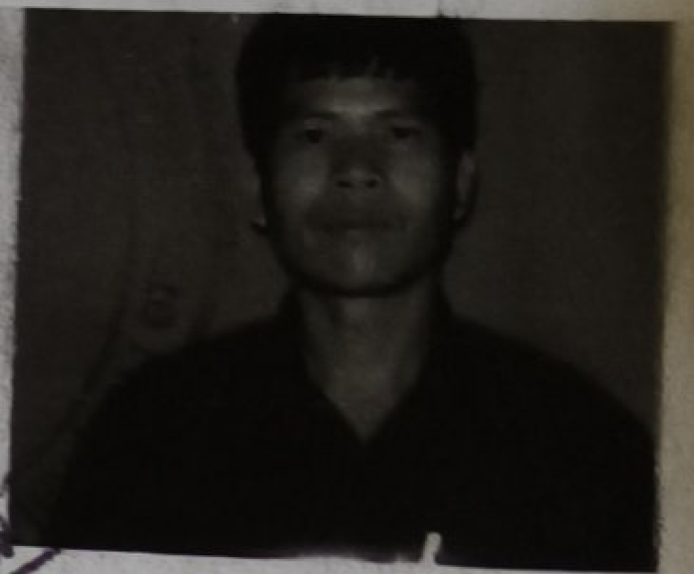
(Page no:- 2)





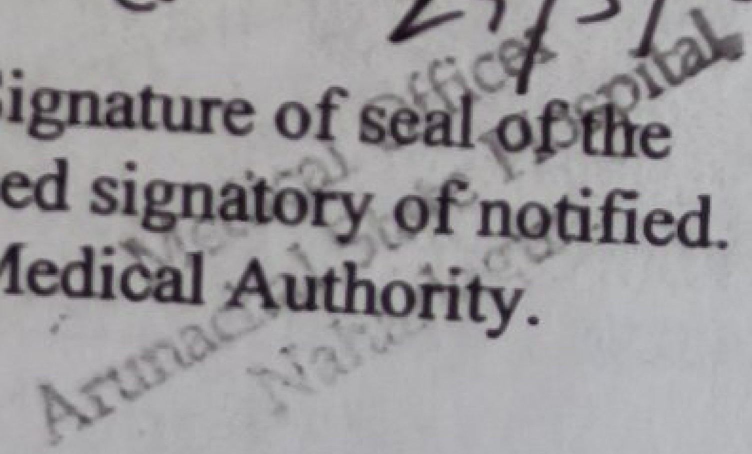
@ He/She has 45 % (In figure forty five percent percent (in words) permanent physical impairment/blindness in relation to his/her disability (part of the body) as per guidelines (to be specified).

2. The applicant has submitted the following documents as proof of residence:-

Nature of documents	date of issue	Details of authority Issuing Certificate.

Signature/Thumb Impression of the Person in whose Favour disability Certificate is issued.

C/S
30/5
(Dr. D. Raina),
Medical Superintendent
Arunachal State Hospital
Naharlagun



(Dr. S. Yomcha)
29/5/12

Signature of seal of the Authorised signatory of notified. Medical Authority.

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