FORM I

Medical Certificate for Blind Candidate

Certified that, I, Dr. ____________________________ Registration No. _____________ have this ___________day of 19 , examined the candidate whose particulars are given below :

1. Name of Candidate :
2. Father's Name :
3. Sex :
4. Approximate Age :
5. Identification mark :
6. Extent of Residual vision, if any — Right eye
Left eye

7 Onset of blindness (Please state whether blindness is from birth or acquired later; if it has been caused afterwards, the age and cause of blindness may be indicated).

(For the purpose of concessions granted to blind candidates; blinds are those who suffer from either of the following :

a) Total absence of sight :

b) Visual acuity not exceeding 6/60 or 20/20 (Snellen) in the better eye with correcting lenses. Limitation of the field of vision sub standing an angle of 20 degrees or worse).

8. Please state clearly whether the candidate is blind who can be considered for the purpose of giving concession, granted by the Board to blind candidates.

Signature of Applicant	(Signature of Ophthalmologist)
Place:	Designation:
Date:	Office Stamp:
	Address :