FORM III

Medical Certificate in respect of an Orthopedically (Physically) Handicapped or spastic candidate

For the purpose of concessions granted to Orthopedically (Physically), handicapped or spastic. The Orthopedically (Physically) handicapped or spastic are those who have Physically defect or deformity which causes an interference with the normal functioning of bones, muscles and joints.

Certified that I, Dr. _____ Registration No._____ have this _____ day of 19 , examined the applicant whose particulars are given below and that he/she falls within the above definition.

1. Name of Candidate :
2. Father's Name :
3. Sex :
4. Approximate Age :
5. Identification mark :
6. (a) Nature of disability (Tick relevant from following list)

POST-POLIO PARALYSIS, HEMIPLEGIA, QUADRAPLEGIA, MALUNITIED FRACTURE, NERVE PARALYSIS, UPPER EXTREMITY, LOWER EXTREMITY, LIMP, PAINFUL, SHORTENING, DEFORMITY, CONGENITAL ACQUIRED, ABOVE KNEE, BELOW KNEE, HIP, HEMIPELVECTOMY, SYMES, CHEOPARTS, WRITS, FINGERS, BELOW ELBOW, ABOVE ELBOW, SHOULDERS, FORE QUARTER, UNILATERAL, BILATERAL.

(b) Extent of disability: Estimate in percentage (mc. Bridge Scale) ON ANATOMICAL, FUNCTIONAL, (PATIENTS ASSESSMENT, EXAMINER'S ASSESSMENT) PERCENTAGE (Please state whether the percentage of disability is 25 or above).

(c) Use of applicant (Tick relevant from following list).
CALLIPER, CMUTCH, ABOVE KNEE, BELOW KNEE, PROSTHESIS, CANE, UNILATERAL, BILATERAL, ABOVE ELBOW, BELOW ELBOW, HEMIPELVECTOMY SHOULDER-DIS-ARTICULATION.

(d) ANY OPERATON DONE OR INDICATED:

(e) PHOTOGRAPH (Attested)

To show the nature of disability and any appliance if used.

7. Any other particulars to clarify the nature and extent of disability that the Surgeon might like to point out.

Signature of applicant
Place:
Date:

(Signature of Orthopaedic Surgeon)
Designation:
Office Stamp:
Address: