(10)

MEDICAL CERTIFICATE FOR THE BLIND.

Certified that I, Dr._____Regn. No._____ have this _____day of _____ 19___, examined the Candidate whose particulars are given below :

Name of Candidate	:
Father's Name	:
Sex	:
Age	:
Occupation	:
Identification Marks	:

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

Whether the disability is Temporary or Permanent.

	RIGHT EYE.	LEFT EYE.
Extent of residual vision (if any).	:	
Total absence of sight.	:	
Visual acquity in the better eye with correcting lenses.	:	
Limitation of the field of vision.	:	

For the purpose of Conveyance Allowance the blind are those who suffer from either of the following(in both eyes) :

(a) Total absence of Sight.

(b) Visual acquity not exceeding 6/60 or 20/200 (Enellen) in the better eye with correcting lenses.

(c) Limitation of the field of vision subtending an angle of 20 degrees or worse.

State clearly whether the candidate is blind for the purpose of Conveyance Allowance:

Signature of the Candidate.

Signature of the Head of Dept. of Opthalmology.
Government Civil Hospital.
Name :
Registration No.:
Designation with Office Seal.
Date :