

**MEDICAL CERTIFICATE FOR THE BLIND**

(G.O.Ms.No. 31, Women’s Development, Child Welfare & Disabled Welfare (DW) Dept.,  
Dt: 01.12.2009).

Certified that the 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
  - i) Right Eye
  - ii) 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).

Pass Port  
Size  
Photograph  
of the  
Candidate  
with the  
Attestation of  
the Issuing  
authority

(For all the purposes of assistance, the blind are those who suffer from either of the following)

- a) Total Absence of sight
  - b) Visual acuity not exceeding 6/60 of 20/200 (Snellen) in the better eye with correcting lenses.
  - c) Limitation of the field of vision subtending an angled 20 degrees of Worse.
- 8. Please state clearly whether the candidate is blind for all purposes of assistance.
  - 9. Specify whether the candidate is totally blind of Partially blind.

SIGNATURE OF APPLICANT

Signature of Ophthalmologist  
District Medical Board.

SIGNATURE OF MEDICAL  
SUPERINTENDENT, (Seal)  
District Medical Board.