

Date:.....

To whom it may concern

This is to inform that Mr./Mrs./Miss
Son/daughter/husband/wife of Mr./Mrs./Miss
permanent resident of Krishnapur municipality ward no..... of age
years has been checked/examined in this clinic/hospital.

As per the examination the Person is diagnosed with following diseases/physical condition:

.....
.....
.....

Hence, It is certified (based on the WHO/National Standard/ Medical standard) that the person is

.....
.....

<i>Nature of Disability</i>	Disability based on physical/functional status
<input type="checkbox"/> Recoverable	<input type="checkbox"/> Physical (deformity).....
<input type="checkbox"/> Non-recoverable
<input type="checkbox"/>	<input type="checkbox"/> Functional.....

Certified by:

Name of doctor:

NMC:

Office Seal