

**FORM - DISABILITY AND  
HAVING DIFFICULTY IN WRITING**

**CERTIFICATE FOR PERSON WITH SPECIFIED DISABILITY COVERED  
UNDER THE DEFINITION OF SECTION 2 (S) OF THE RPWD ACT, 2016  
BUT NOT COVERED UNDER THE DEFINITION OF SECTION 2(R) OF  
THE SAID ACT, i.e. PERSONS HAVING LESS THAN 40% DISABILITY  
AND HAVING DIFFICULTY IN WRITING**

This is to certify that, we have examined Mr/Ms/Mrs. \_\_\_\_\_  
(name of the candidate), S/o /D/o \_\_\_\_\_, a resident of  
\_\_\_\_\_ (Vill/PO/PS/District/State), aged  
\_\_\_\_\_ years, a person with \_\_\_\_\_ (nature of  
disability/condition), and to state that he/she has limitation which hampers his/her writing  
capability owing to his/her above condition. He/she requires support of scribe for writing  
the examination.

2. The above candidate uses aids and assistive device such as prosthetics & orthotics,  
hearing aid (name to be specified) which is/are essential for the candidate to appear at the  
examination with the assistance of scribe.

3. This certificate is issued only for the purpose of appearing in written examinations  
conducted by recruitment agencies as well as academic institutions and is valid up to  
\_\_\_\_\_ (it is valid for maximum period of six months or less as may be certified by  
the medical authority)

Signature of medical authority

(Signature & Name)	(Signature & Name)	(Signature & Name)	(Signature & Name)	(Signature & Name)
Orthopedic/ PMR specialist	Clinical Psychologist / Rehabilitation Psychologist / Psychiatrist / Special Educator	Neurologist (if available)	Occupational Therapist (if available)	Other Expert, as nominated by the Chairperson (if any)
(Signature & Name)				
Chief Medical Officer / Civil Surgeon / Chief District Medical Officer ..... Chairperson				

Name of Government Hospital / Health care Centre with Seal

Place:

Date: