Annexure-A

FORM FOR ASSESSING FUNCTIONAL REQUIREMENTS (FOR PERSONS WITH DISABILITIES)

(in reference to DEPwD Notification dated 04.01.2021)

To be filled by candidate

Name of candidate:
Signature of Candidate: Date:

To be filled by doctor *(Medical Officer of Government Hospital of the rank of Civil Surgeon/Medical Superintendent)*

This is to certify that Mr./Ms./Mrs. _____ S/o | D/o _____ having Disability Certificate/ ID No: _____, meets the following functional requirements for discharge of his/her duties, using aids and assistive devices:

(Please tick the applicable box)

Functional Requirement	Yes	No
S- can perform work by sitting		
ST- can perform work by standing		
W- can perform work by walking		
BN- can perform work by bending		
RW- can perform work by reading and writing		
SE- can perform work by seeing		
H- can perform work by hearing		
C- can perform work by communicating		
MF- can perform work by manipulation by fingers		

Seal & Signature of Doctor:

Date:

Name:

Registration No: