ANNEXURE to G.O. No.FD 24 SRP 2018(VII) dated 11th January 2019

Form

(Applicable to Orthopaedically Handicapped /Blind Government employees)

Orthopaedics/ Ophthalmology Department, Government Hospital……

Sl. No.

I hereby certify that I have examined Shri/Smt…… who is said to have been employed in …… …….. as (designation) …… and whose signature is attested by me, is a candidate for sanction of conveyance allowance as stipulated in G.O.No. FD 1 SRP 79 dated 14th February 1979 read with G.O. dated: ---- 01.2019. After the detailed examination, I find that he/she has got the following permanent/partial disability of ……..... ……/ total blindness (both eyes)/ blindness* as defined in para 1(B) of the **SCHEDULE TO THE RIGHTS OF PERSONS WITH DISABILITIES ACT, 2016**

(1)

(2)

(3)

(4)

In conclusion, I am of the opinion that the total permanent disability is up to …….. percentage of both upper and lower extremities/both eyes and requires physical assistance to comute to work place. He/she is eligible / not eligible for the conveyance allowance as per G.O. No. FD 1 SRP 79 dated 14th February 1979 read with G.O. dated: 11.01.2019.

Specimen signature of the Candidate or
Left thumb impression.

Signature and designation of the Head of the
Department of Orthopaedics/ Ophthalmology,
Government Hospital.

Date:

Place:

* Strike out whichever is not applicable.