

## Medical Certificate for the Blind

Certified that I, Dr. ....  
Registration No..... have this.....  
Day of .....200..... examined the candidate whose  
particulars are given below.

1. Name of candidate
2. Father 's name
3. Sex
4. Approximate
5. Identification mark
6. Extend of residual vision, If any R.E.  
L.E.
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 ) For the purpose of these scholarship the blind are those who suffer from either of the following.
  - a) Total absence of sight
  - b) Visual acuity not exceeding 6/60 of20/200 (snellen ) in the better eye with correcting lence
  - c) Limitation of the field of vision sub standing Lence.
8. Please State clearly whether the candidate is blind for the purpose of scholarship.

Signature of application

( Signature of Ophthalmologist )

Place  
Date

Designation  
Office Stamp  
Address