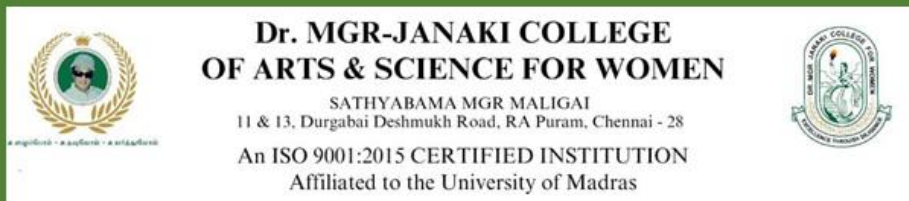


CRITERION 2



TEACHING LEARNING AND EVALUATION



CRITERION 2

2.1: STUDENT ENROLMENT AND PROFILE

2.1.2. DIVYANGJAN



Verified and Certified Documents

Metric No: 2.1.2

Page No 4 to 60



Janimgeled
Principal

PRINCIPAL
DR. MGR JANAKI COLLEGE OF
ARTS & SCIENCE FOR WOMEN
CHENNAI - 600 028.

LIST OF SPECIAL CHILDREN 2018– 2019			
S.NO	Name	Department	Catagry
1	SWETHA. T	B.COM(G)	HEARING IMPAIRED
2	MAHESHWARI. S	B.COM(G)	HEARING IMPAIRED
3	NIVEDHA. M	B.COM(A/F)	HEARING IMPAIRED
4	PRIYA. S	B.COM(A/F)	HEARING IMPAIRED
5	PUNITHA. S	B.COM(A/F)	HEARING IMPAIRED
6	MALASREE. R	BBA	HEARING IMPAIRED
7	UMA PARAVATHY. G	B.COM(A/F)	HEARING IMPAIRED
8	LAVANYA. S	B.COM(A/F)	HEARING IMPAIRED
9	VISALATCHI. S	B.COM(A/F)	HEARING IMPAIRED
10	SARASWATHI. K	B.COM(BM)	HEARING IMPAIRED
11	LOGESHWARI. M	B.COM(BM)	HEARING IMPAIRED

12	SANGEETHA. S	B.COM(BM)	HEARING IMPAIRED
13	PREETHI. R	BBA	HEARING IMPAIRED
14	NARMADHA	BBA	HEARING IMPAIRED
15	MAHALAKSHMI. V	BBA	HEARING IMPAIRED
16	PRIYANKA	BBA	HEARING IMPAIRED
17	RESHMA MARY. H	BBA	HEARING IMPAIRED
18	REKHA. D	BCA	HEARING IMPAIRED
19	SOWMIYA. K	BCA	HEARING IMPAIRED
20	C.SREEKAMAKSHI	BSC (CS)	DOWM SYADROME
21	M.SHANMATHI	B.A ENGLISH	DOWM SYADROME
22	V.SRIGAYATHRI	B.A ENGLIISH	LEARING DISORDER
23	N.SANJANA	B.A ENGLIISH	DYSLEXIA
24	M.DHANUVASHINI	M.A ENGLISH	CESHRAL PALSY

25	NIKITHA	M.A ENGLISH	CESHRAL PALSYP
26	RESHIKA	M.A HRM	LEARING DISORDER
27	B.BHUVANESWARI	B.B.M	DYSLEXIA
28	MANESWARI.E	B.B.A	VISUALLY IMPARIED
29	R.POORAVJA	B.A ENGLISH	MENTAL DISABILITY
30	R.GIYAPRIYAA	B.A. ENGLISH	MENTAL DISABILITY
31	PREETHA CELAH	B.A. ENGLISH	VISUALLY IMPARIED
32	VIJAYA VARSHINI	B.B.A	MENTAL DISABILITY

DISABILITY CERTIFICATE



In cases other than those mentioned in Form II and III)

NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

(See rule 4)



Certificate No. 32TC/HI/6

Date:

This is to certify that I have carefully

examined

ENT Specialist,

Assistant Surgeon,

Tamil Nadu Medical Services

Shri/Smt./Kum. T. SURETHA

Son/wife/daughter of

Shri K. THAMILARASAN

Date of Birth 27 / 1 / 1999 Age 15 years, Male / female FEMALE
(DD / MM / YY)

Registration No. CHN/HI/06858 Permanent resident of House

No. 16/31 Ward / Village / Street Perumal Koil St. Post

Office Arumbakkam District Ch - 106 State

Whose photograph is affixed above, and am satisfied that he/she is a case of Speech & Hearing disability. His / her extent of percentage physical impairment / disability has been evaluated as per guidelines (to be specified and is shown against the relevant disability in the table below.

No.	Disability	Affected part of Body	Diagnosis	Permanent physical impairment / Mental Disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both Eyes		
4.	Hearing Impairment	£	B/LP <u>SH</u>	100 %
5.	Mental Retardation	X		
6.	Mental Illness	X		

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :
(i) not necessary,

Or
(ii) is recommended/ after _____ years _____ months, and therefore
this certificate shall be valid till _____

(DD)

(MM)

(YY)

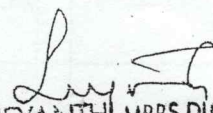
4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate

A. T. 51821517

Signature/Thumb impression of the
Person in whose Favor disability
Certificate is issued

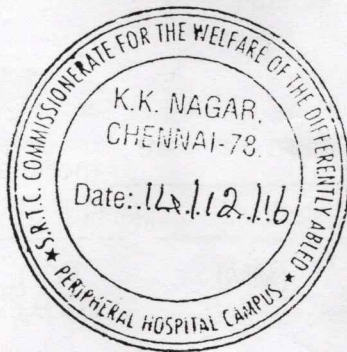
PRINCIPAL
DR. MGR JANAKI COLLEGE OF
ARTS & SCIENCE FOR WOMEN
CHENNAI-600 028.


DR. N. JAYANTHI, MBBS, DLO
(Authorized Signatory of notified Medical
Authority (Name and seal)
(Counter signature and seal of the
CMO/Medical Superintendent/Head of
Government Hospital, in case the
Certificate is issued by a medical author-
ity who is not a government servant (with
seal)

Form - IV
Disability Certificate

(In cases other than those mentioned in Forms II and III)

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:



Tamil Nadu Medical Services

Certificate No. KPM (H2) 664105

Date: 14/12/2015

This is to certify that I have carefully examined

Shri/Smt./Kum. S. MAHESWARI

son/wife/daughter of Shri C. SUBRAMAN Date of

Birth 01 02 1999 Age 16 years, male/female FEMALE.
(DD / MM / YY)

Registration No. KPM/H2/664105 permanent resident of House No. DR. MUR SCHOOL (H2)

Ward/Village/Street Ramapuram, CH-89 Post-Office _____ District

KANCHI PURAM State TAMIL NADU whose photograph is affixed

above, and am satisfied that he/she is a case of H2 Speech & Hearing Disability. His/her

extent of permanent physical impairment/disability has been evaluated as per guidelines
(to be specified) and is shown against the relevant disability in the table below:-

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both eyes		
4.	Hearing Impaired	Both ears	Profound SNHL	100% (Hundred)
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months, and therefore

this certificate shall be valid till _____

(DD)

(MM)

(YY)

@ e.g. Left/Right/both arms/legs

e.g. Single eye/both eyes


£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate

S. 1080000000

Signature/Thumb Impression of the
Person in whose Favour disability
Certificate is issued


(Authorized Signatory of notified Medical
Authority Name and seal)
(Counter signature and seal of the
CMO/Medical Superintendent/Head of
Government Hospital, in case the
Certificate is issued by a medical authority
who is not a government servant (with
seal))

FORM - IV**Disability Certificate**

(In cases other than those mentioned in Forms II and III)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

(See rule 4)



DR. N. Jeyanthi, D.O., ENT SPECIALIST

Date : REG NO: 58527

Certificate No.

This is to certify that I have carefully examined

Shri / Smt. / Kum. M. Nivedhason / wife / daughter of Shri Gr. MuruganDate of Birth 06 07 1998 Age 14 years, Male / Female Female
(DD) (MM) (YY)Registration No. CHN/HE/02014 Permanent resident of House No. 791Ward / Village / Tolgate Street S.A. Colony Post Office _____District Chennai State Tamil Nadu

whose photograph is affixed above, and am satisfied that he/she is a case of Speech & Hearing disability, His/her extent of percentage physical impairment / disability has been evaluated as per guidelines (to be specified and is shown against the relevant disability in the table below :

S.No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment / Mental Disability (in%)
1.	Locomotor Disability	@		
2.	Low vision	#		
3.	Blindness	Both Eyes		
4.	Hearing Impairment	£	Bilateral SNHL	100%
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

2. This above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary, (or)

(ii) is recommended / after _____ years _____ months, and therefore this Certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left / Right / both arms / legs

e.g. Single eye / both eyes

£ e.g. Left / Right / both ears

4. The applicant has submitted the following documents as proof of residence:-

Nature of Document	Date of issue	Details of authority issuing Certificate

(Authorised Signatory of notified Medical Authority)
(Name and Seal)

DR.N.JEYANTHI,MBBS,DLO.

REG NO:56577

Countersigned

ENT SPECIALIST

ASSISTANT SURGEON

TAMILNADU MEDICAL SERVICES

(Countersignature and seal of the
Medical Superintendent,
Government Hospital, in
case the Certificate is issued
by a Medical Authority who is
not a government servant (with
seal))

M. Reason

Signature / Thumb
impression of the person in whose
favour Disability certificate is
issued.

Note : In case this certificate is issued by a medical authority who is not a government servant, it shall be valid only if countersigned by the Chief Medical Officer of the District"

Note : The principal rules were published in the Gazette of India vide notification number S.O. 908(E), dated the 31st December, 1996

Form-IV

DISABILITY CERTIFICATE

(In cases other than those mentioned in Form II and III)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

(See rule 4)



Certificate No.

This is to certify that I have carefully

Date:

Dr. N. J. E.

Re

examined

Assistant Surgeon

Tamil Nadu Medical Services

Son / wife daughter of

Shri/Smt./Kum. S. PRIYA

Shri N. Sivalingam

Date of Birth 18 07 1997 Age 16 years, Male / female female
(DD / MM / YY)

Registration No. TN/CHN/HL/02080 Permanent resident of House

No. 21/11 Ward / Village / Street Santhiyappan et Post

Office Otteri District Chennai State Tamil Nadu

Whose photograph is affixed above, and am satisfied that he/she is a case of Speech & Hearing disability. His / her extent of percentage physical impairment / disability has been evaluated as per guidelines (to be specified and is shown against the relevant disability in the table below.

S.No.	Disability	Affected part of Body	Diagnosis	Permanent physical impairment / Mental Disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both Eyes		
4.	Hearing Impairment	£	B/L Pngg SN 12	100%
5.	Mental Retardation	X		
6.	Mental Illness	X		

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

✓ (i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months, and therefore this certificate shall be valid till _____

(DD)

(MM)

(YY)

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate

Signature/Thumb Impression of the Person in whose Favor disability Certificate is issued

Signature/Thumb Impression of the Person in whose Favor disability Certificate is issued

Signature/Thumb Impression of the Person in whose Favor disability Certificate is issued

Authorized Signatory of notified Medical Authority (Name and seal)
ENT Specialist
Assistant Surgeon
Medical Superintendent/Head of Government Hospital, in case the Certificate is issued by a medical authority who is not a government servant (with seal)



Government of Andhra Pradesh

CERTIFICATE FOR PERSON WITH DISABILITY

(Issued under the authority vide G.O.Ms.No.31, WD CW & DW Dept.Dated 01.12.2009)



Medical Board: S.V.Medical College, Tirupathi
ID No.of Person with Disability: 10137880240000013
Date of Issue: 07/11/2014

- This is certified that Kumari S Punitha, D/o R Selvam, Female, age 15 years, resident of H.No.# 6-155, 24TH WARD Habitation, 24th Ward Village, Nagari (muni) Mandal, Chittoor District, is suffering from Permanent disability of the following category:-
Hearing Impairment (Profound).
Loss of 100(Hundred) decibels in the better ear in the conversational range of frequencies .

Cause of Disability : Congenital.
DEAF DUMB.

- Re-assessment of this case is not recommended.
- Percentage of disability in her case is 100% [Hundred percent].
- Identification Marks of Person with Disability:-
a)A Mole On The Right Side Cheek .
b)A Mole On The Right Chest .

S. JOSTEN
Signature/Thumb impression
of Person with Disability

Signature

Dr. CHANDRASEKHAR

Designation: ASSOCIATE
PROFESSOR

Regn.No : 17211

ENT SURGEON

Signature

Dr. C.VARA SUNDHARAM

Designation: CS RMO

Regn.No : 15609

CIVIL SURGEON - R.M.O

Signature

Dr. J.VEERASWAMY

Designation: Medical
Superintendent

Regn.No : 13798

CHAIRMAN

Note: This is not valid for Medico-Legal cases.



AUDIO GRAM / AUDIOLOGICAL EVALUATION CHART

NAME : S. Punika

No. :

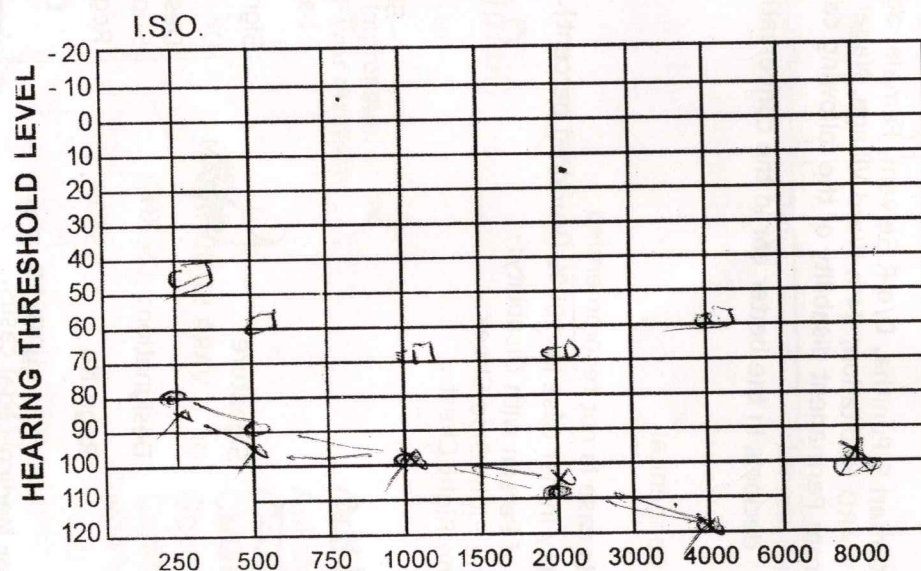
AGE : 15 E

DATE :

06/11/14

TEST No. :

TESTED BY :



AIR CONDUCTION :

UN-MASKED :

MASKED :

Rt. Lt.

0 X

Δ ∇

BONE CONDUCTION :

UN MASKED

MASKED

A.C. NOT HEARD

B.C. NOT HEARD

AUDIO METER :

PROCEDURE :

STANDARD / PLAY AUDIO METRY

	RIGHT	LEFT	AID IN EAR	
			RT.	LT.
3 FREQUENCY AVERAGE	100 dB	100 dB		
S.R.T.				
DISCRIMN (P.B. MAX)				

AUDIOLOGIST

FORM - IV

Disability Certificate

(In cases other than those mentioned in Forms II and III)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

(See rule 4)



DR. N

BS, DLO.

Certificate No.

Date: ENT SPECIALIST

This is to certify that I have carried out a physical examination of the patient and am satisfied that he/she is a case of TAMILNADU MEDICAL SERVICES

Shri / Smt. / Kum. R. MALA SREE

son / wife / daughter of Shri M. RAMACHANDRAPPA

Date of Birth 21 12 94 Age 18 years, Male / Female FEMALE
(DD) (MM) (YY)

Registration No. TN CHN HL 42456 Permanent resident of House No.

Ward / Village / Pottokotta Street Hosur Post Office VADANAPALLI

District KRISHNAGIRI State TAMIL NADU

whose photograph is affixed above, and am satisfied that he/she is a case of Speech & Hearing disability, His/her extent of percentage physical impairment / disability has been evaluated as per guidelines (to be specified and is shown against the relevant disability in the table below :

S.No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment / Mental Disability (in%)
1.	Locomotor Disability	@		
2.	Low vision	#		
3.	Blindness	Both Eyes		
4.	Hearing Impairment	£	<u>Bilateral</u> <u>with</u>	<u>100 %</u>
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

2. This above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

~~1)~~ not necessary, (or)

(ii) is recommended / after _____ years _____ months, and therefore this Certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left / Right / both arms / legs

e.g. Single eye / both eyes

£ e.g. Left / Right / both ears

4. The applicant has submitted the following documents as proof of residence:-

Nature of Document	Date of issue	Details of authority issuing Certificate

(Authorised Signatory of notified Medical Authority)

[Signature]
2/12/12 (Name and Seal)

DR.N.JEYANTHI,MBBS,DLO.

REG NO:56577

Countersigned

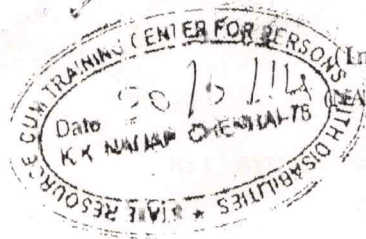
ENT SPECIALIST
ASSISTANT SURGEON
TAMILNADU MEDICAL SERVICES
Countersignature and seal of the
CMO/ Medical Superintendent /
Head of Government Hospital, in
case the Certificate is issued
by a Medical Authority who is
not a government servant (with
seal))

B mala sree

Signature / Thumb
impression of the person in whose
favour Disability certificate is
issued.

Note : In case this certificate is issued by a medical authority who is not a government servant, it shall be valid only if countersigned by the Chief Medical Officer of the District"

Note : The principal rules were published in the Gazette of India vide notification number S.O. 908(E), dated the 31st December, 1996



Form-IV

DISABILITY CERTIFICATE

(In cases other than those mentioned in Form II and III)
NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING
THE CERTIFICATE)
(See rule 4)



Date: 08/01/14

Certificate No.

This is to certify that I have carefully

Shri / Smt / Kum. G. UMA PARVATHY

Shri S. Gnanaprasadam

Date of Birth 12 12 1997 Age 16 years, Male / female female
(DD / MM / YY)

Registration No. CHN/HZ / 01851 Permanent resident of House

No. 40/105 Ward / Village / Street Kothavalavadi Post

Office West Saidapet District Chennai State Tamil Nadu

Whose photograph is affixed above, and am satisfied that he/she is a case of Speech & Hearing disability. His / her extent of percentage physical impairment / disability has been evaluated as per guidelines (to be specified and is shown against the relevant disability in the table below.

S.No.	Disability	Affected part of Body	Diagnosis	Permanent physical impairment / Mental Disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both Eyes		
4.	Hearing Impairment	£	B/L Profound	100%
5.	Mental Retardation	X		
6.	Mental illness	X		

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :
(i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months, and there-on:
this certificate shall be valid till _____

(DD)

(MM)

(YY)

4. The applicant has submitted the following document as proof of residence :-

Nature of Document	Date of Issue	Details of authority issuing certificate

ச. உதயசுந்தரி.

Signature/Thumb Impression of the
Person in whose Favor disability
Certificate is issued

(Authorized Signatory of notified Medical
Authority Name and sea)
(Countersignature and sea of the
CMO/Medical Superintendent/ Head of
Government Hospital, in case the
Certificate is issued by a medical authority
who is not a government servant (with
seal))

DISABILITY CERTIFICATE

(See rule 4)



Date:

This is to certify that I have carefully

Shri / Smt. / Kum.....S. LAVANYA

Shri.....D. SUKUMAR.....

Date of Birth 12 / 11 / 1997 Age 16 years, Male / female female
(DD / MM / YY)

Registration No. CHN/HI/01852 Permanent resident of House

No. 13 Ward / Village / Street Vinayagapuram Post

Office West Sridipet District Chennai State Tamilnadu

Whose photograph is affixed above, and am satisfied that he/she is a case of Speech & Hearing disability. His / her extent of percentage physical impairment / disability has been evaluated as per guidelines (to be specified and is shown against the relevant disability in the table below.

S.No.	Disability	Affected part of Body	Diagnosis	Permanent physical impairment / Mental Disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both Eyes		
4.	Hearing Impairment	£	B/L Pnpal ear m	100 %.
5.	Mental Retardation	X		
6.	Mental Illness	X		

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months, and therefore this certificate shall be valid till _____

(DD)

(MM)

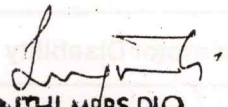
(YY)

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate

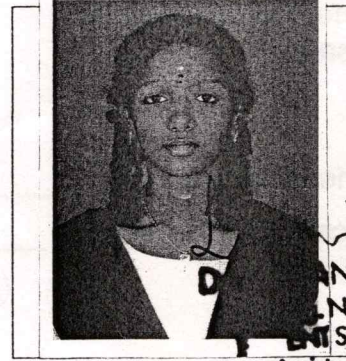
ச. சுவாமிநாதன்

Signature/Thumb Impression of the Person in whose Favor disability Certificate is issued


Dr. N. JEYANTHI, MBBS, DLO
(Authorized Signatory of notified Medical Officer and seal)
(County Surgeon and seal of the CMO/Medical Superintendent/Head of Government Hospital, in case the Certificate is issued by a medical authority who is not a government servant (with seal))

Form - IV
Disability Certificate
(In cases other than those mentioned in Forms II and III)

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:



Certificate No. SRTC/HS/15

Date: 18/9/15

This is to certify that I have carefully examined

Shri/Smt./Kum. S. VISALATCHI

son/wife/daughter of Shri G.K. SANKAR Date of

Birth 06 05 2000 Age 15 years, male/female Female

(DD / MM / YY)

Registration No. CAN/HS/18424 permanent resident of House No. 76/43 Gampathy St.

Ward/Village/Street Chennai-33 Post-Office West mambalam District

Chennai State Tamil Nadu whose photograph is affixed
above, and am satisfied that he/she is a case of Speech & Hearing Disability. His/her

extent of permanent physical impairment/disability has been evaluated as per guidelines
(to be specified) and is shown against the relevant disability in the table below:-

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both eyes		
4. ✓	Hearing Impaired	£	B/L Pmpg/ SWM	100 %
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :
(i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months, and therefore
this certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left/Right/both arms/legs

e.g. Single eye/both eyes

£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate
Portion @RN	June 2005	CS CPD

1 S. Visalatchi

Signature/Thumb Impression of the
Person in whose Favour disability
Certificate is issued

Dr. N. JEYANTHI, MBBS, DLO
(Authorized Signatory of notified Medical
Authority, Name and seal)
ENT Specialist
Assistant Surgeon
Government Medical Services
Signature and seal of the
CMO/Medical Superintendent/Head of
Government Hospital, in case the
Certificate is issued by a medical authority
who is not a government servant (with
seal)

Form - IV
Disability Certificate
(In cases other than those mentioned in Forms II and III)

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:



Certificate No. KPM (HI) 693/05

Date: 22/12/15

This is to certify that I have carefully examined
Shri/Smt./Kum. K. Saraswathi
son/wife/daughter of Shri C. Kanniyappan Date of
Birth 14 08 1995 Age 20 years, male/female Female
(DD / MM / YY)

Registration No. KPM/HI/693/05 permanent resident of House No. Dr. MGR School
Ward/Village/Street Ramapuram Post-Office _____ District
Chennai - 89 State Tamilnadu whose photograph is affixed
above, and am satisfied that he/she is a case of Speech & Hearing **Disability**. His/her
extent of permanent physical impairment/disability has been evaluated as per guidelines
(to be specified) and is shown against the relevant disability in the table below:-

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both eyes		
<u>4.</u>	Hearing Impaired	<u>Both ears.</u>	<u>Profound SN hearing loss.</u>	<u>100% (Hundred)</u>
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months, and therefore
this certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left/Right/both arms/legs

e.g. Single eye/both eyes

£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate

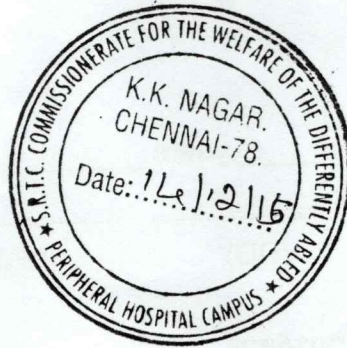
K. SaraShwathi

Signature/Thumb Impression of the
Person in whose Favour disability
Certificate is issued

Dr. N. JEYANTHI, MBBS, DLO
Reg. No: 56577
(Authorized Signatory, of notified Medical
Authority (Name and seal)
(Counter signature and seal of the
CMO/Medical Superintendent/Head of
Government Hospital, in case the
Certificate is issued by a medical authority
who is not a government servant (with
seal)

Form - IV
Disability Certificate
(In cases other than those mentioned in Forms II and III)

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:



[Signature]
M.B.B.S., D.O.
No: 56577
Specialist,
Surgeon
Medical Services

Certificate No. KPM (H2) 20668. Date: 14/12/2015.
This is to certify that I have carefully examined
Shri/Smt./Kum. M. LOKESHWARI
son/wife/daughter of Shri S. MURUGAN Date of
Birth 25 01 1999 Age 16 years, male/female
(DD / MM / YY)

Registration No. KPM/H2/20668 permanent resident of House No. 3/46, Newno. 6
Ward/Village/Street Kizh Kovalavedu Post-Office _____ District
Thiruvannamalai State TAMILNADU whose photograph is affixed
above, and am satisfied that he/she is a case of HR Speech & Hearing Disability. His/her
extent of permanent physical impairment/disability has been evaluated as per guidelines
(to be specified) and is shown against the relevant disability in the table below:-

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both eyes		
4. ✓	Hearing Impaired	Both ears	Profound SNHL	100%. (Hundred)
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.
3. Reassessment of disability is :
(i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months, and therefore this certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left/Right/both arms/legs

e.g. Single eye/both eyes

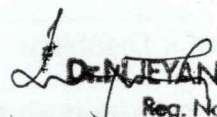
£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate

M. சோகேஸ்வரி.

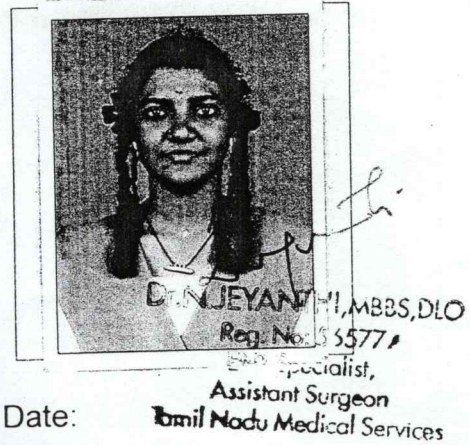
Signature/Thumb Impression of the Person in whose Favour disability Certificate is issued

 **Dr. N. JEYANTHI**, MBBS, DLO
Reg. No: 56577

(Authorized Signatory of notified Medical Authority (Name and seal))
(Counter signature and seal of the CMO/Medical Superintendent/Head of Government Hospital, in case the Certificate is issued by a medical authority who is not a government servant (with seal))

Form - IV
Disability Certificate
(In cases other than those mentioned in Forms II and III)

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:



Certificate No. _____

Date: _____

carefully examined

This is to certify that I have
Shri/Smt./Kum. S. SANGEETHA
son/wife/daughter of Shri D. SEKAR Date of
Birth 18 06 1998 Age 17 years, male/female FEMALE
(DD / MM / YY)

Registration No. _____ permanent resident of House No. _____

Ward/Village/Street DR. MGR SCHOOL FOR THE HI Post-Office _____ District

KANCHEEPURAM State TAMIL NADU whose photograph is affixed

above, and am satisfied that he/she is a case of Speech & Hearing **Disability**. His/her

extent of permanent physical impairment/disability has been evaluated as per guidelines

(to be specified) and is shown against the relevant disability in the table below:-

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both eyes		
4. ✓	Hearing Impaired	Both Ears	Profound SN hearing loss.	100% (Hundred)
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

FORM - IV

DISABILITY CERTIFICATE

(in cases other than those mentioned in Forms II and III)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

(See rule 4)

Certificate No.

Date:



This is to certify that I have carefully examined

Shri + Smt./ Kum. R. Dheethi

son/wife/daughter of Shri N. Ramesh.

Date of Birth 16.1.1999 Age 16 years, Male/female _____
(DD/MM/YY)

Registration No. Sarikutri village R Post permanent resident of _____ House

No. Pennambur Ward/Village/Street _____ Post

Office _____ District _____ State _____

whose photograph is affixed above, and am satisfied that;

S.No.	Disability	Affected Part of Body	Diagnosis	Permanent Physical impairment/Mental Disability (in%)
1	Locomotor Disability	@		
2	Low Vision	#		
3	Blindness	Both Eyes		
4	Hearding Impairment	£		
5	Mental Retardation	X		
6	Mental Illness	X		

Handwritten notes and signatures:
Bled... found... / Hearing loss
Spec...
Set (Nidhi)

1. Please Strike Out the disabilities which are not applicable)
2. This above condition is progressive / non - progressive / likely to improve / not likely to improve
3. Reassessment of disability is:
 - (i) Not necessary, (or) ☒
 - (ii) is recommended / after _____ years _____ months, and therefore this. Certificate shall be valid till _____

(DD) (MM) (YY)

@ e.g. Left / Right / both arms / legs

e.g. Single eye / both eyes

£ e.g. Left / Right / both ears

4. The applicant has submitted the following document ad proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing Certificate

26-20/5

(Authorised Signatory to Medical Authority)
 Dr. S. SENTHIL KANNAN
 Chief Civil Surgeon,
 ENT Specialist, (Name and Seal)
 Pentland Hospital,
 VELLORE - 1.

Countersigned
 (Countersignature and Seal of the
 CMO / Medical Superintendent /
 Head of Government. Hospitals in
 case the certificate is issued
 by a Medical Authority who is
 not a government servant (with seal)

Signature / Thumb.
 impression of the person
 in whose favour disability
 certificate is issued.

Note : In case this Certificate is issued by a medical authority who is not a government Servant, it shall be valid only if countersigned by the Chief Medical Officer of the District"

Note : The Principal rules were published in the Gazette of India vide notification number S.O. 908 (E), dated the 31st December, 1996.

FORM - IV**Disability Certificate**

(In cases other than those mentioned in Forms II and III)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

(See rule 4)



DR. J. EYAN HENRISS, D.
REG NO: 50577
ENT SPECIALIST
ASSISTANT SURGEON
TAMILNADU MEDICAL SERVICE

Certificate No. _____

Date : _____

This is to certify that I have carefully examined

Shri / Smt. / Kum. R. Narmathason / wife / daughter of Shri G. RaviDate of Birth 13 12 1998 Age 13 years, Male / Female female
(DD) (MM) (YY)Registration No. _____ Permanent resident of House No. 10/53Ward / Village / villivakkam Street fifth Post Office _____District chennai State Tamilnadu

whose photograph is affixed above, and am satisfied that he/she is a case of Speech & hearing disability, His/her extent of percentage physical impairment / disability has been evaluated as per guidelines (to be specified and is shown against the relevant disability in the table below :

S.No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment / Mental Disability (in%)
1.	Locomotor Disability	@		
2.	Low vision	#		
3.	Blindness	Both Eyes		
4.	Hearing Impairment	£	<u>Bilateral</u> <u>SNHL</u>	<u>100%</u>
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

2. This above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary, (or)

(ii) is recommended / after _____ years _____ months, and therefore this Certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left / Right / both arms / legs

e.g. Single eye / both eyes

£ e.g. Left / Right / both ears

4. The applicant has submitted the following documents as proof of residence:-

Nature of Document	Date of issue	Details of authority issuing Certificate

(Authorised Signatory of notified Medical Authority)
(Name and Seal)

DR.N.JEYANTHI.MBBS,DLO.
REG NO:56577
ENT SPECIALIST
ASSISTANT SURGEON
TAMILNADU MEDICAL SERVICES

Countersigned

(Signature and seal of the
GMO / Medical Superintendent /
Head of Government Hospital, in
case the Certificate is issued
by a Medical Authority who is
not a government servant (with
seal))

R. 151058

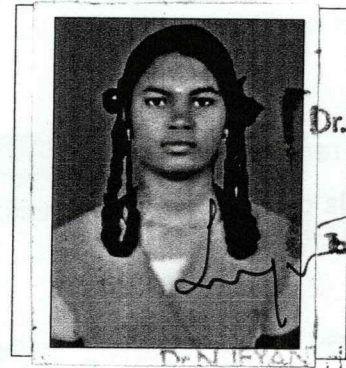
Signature / Thumb
impression of the person in whose
favour Disability certificate is
issued.

Note : In case this certificate is issued by a medical authority who is not a government servant, it shall be valid only if countersigned by the Chief Medical Officer of the District"

Note : The principal rules were published in the Gazette of India vide notification number S.O. 908(E), dated the 31st December, 1996

Form - IV
Disability Certificate
(In cases other than those mentioned in Forms II and III)

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:



Dr. N. JEYANTHI, MBBS, DLO
Reg. No: 56577
ENT Specialist,
Assistant Surgeon
Tamil Nadu Medical Services

Certificate No. _____

Date: _____

Reg. No: 56577
ENT Specialist,
Assistant Surgeon
Tamil Nadu Medical Services

This is to certify that I have **carefully** examined

Shri/Smt./Kum. MAHALAKSHMI . V

son/wife/daughter of Shri VASUDEVAN Date of

Birth 15 01 1998 Age 18 years, male/female FEMALE
(DD / MM / YY)

Registration No. _____ permanent resident of House No. 57

Ward/Village/Street AMMAN KOVIL STREET Post-Office KUNDRATHUR District

KANCHIPURAM State TAMILNADU whose photograph is affixed
above, and am satisfied that he/she is a case of Speech & Hearing **Disability**. His/her

extent of permanent physical impairment/disability has been evaluated as per guidelines
(to be specified) and is shown against the relevant disability in the table below:-

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both eyes		
4.	Hearing Impaired	£	<u>Bilateral</u> <u>SNHL</u>	<u>100 %</u>
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

(4)

Form - IV
Disability Certificate
(In cases other than those mentioned in Forms II and III)

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:



JANTHI, MBBS, DLO
Reg. No: 56577
ENT Specialist,
Assistant Surgeon
Tadu Medical Services

Certificate No. KPM (H2) 667.

Date: 14/12/2015.

This is to certify that I have carefully examined

Shri/Smt./Kum. M. PRIYANKA.

son/wife/daughter of Shri V. MURUGAN. Date of

Birth 16 02 1998 Age 17 years, male/female _____
(DD / MM / YY)

Registration No. KPM/H2/667 permanent resident of House No. DR. MUR SUTRA CAD

Ward/Village/Street RAMAPURAM. Post-Office _____ District

CHENNAI - 89. State TAMIL NADU. whose photograph is affixed
above, and am satisfied that he/she is a case of HR Speech & Hearing Disability. His/her

extent of permanent physical impairment/disability has been evaluated as per guidelines
(to be specified) and is shown against the relevant disability in the table below:-

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both eyes		
4. ✓	Hearing Impaired	Both ears	Profound SNHL	100%. (Hundred)
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months, and therefore
this certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left/Right/both arms/legs

e.g. Single eye/both eyes

£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate

M. Priyanka

Signature/Thumb Impression of the
Person in whose Favour disability
Certificate is issued

Dr. N. JEYANTHI, MBBS, DLO

Reg. No: 56577

ENT Specialist,

Assistant Surgeon

Tamil Nadu Medical Services

(Authorized Signatory of notified Medical
Authority (Name and seal)

(Counter signature and seal of the
CMO/Medical Superintendent/Head of
Government Hospital, in case the
Certificate is issued by a medical authority
who is not a government servant (with
seal)

FROM - IV
Disability Certificate

(In cases other than those mentioned in Forms II and III)
(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)
(See Rule 4)



Certificate No. _____

Date: 6.11.2015 Dr. R. MEI Asst. Surgeon Regd. No. 518 Govt. PHC., Thiruvallur

This is to certify that I have carefully examined

Shri/Smt./ Kum. Reshma Mary

Son/Wife/daughter of Shri Hector Michael Ray

Date of Birth 18.2.1998 Age 17 Years, Male/Female Female

Registration No. 4837 Permanent resident of House No. 2-18/15

Ward/Village/ Kulmarickan Street Main Road, Post Office

Kulmarickan District Arignankott State Tamil Nadu

Whose Photograph is affixed above, and am satisfied that he/she is a case of

Deaf & Dumb disability, His/her extent of percentage physical impairment/disability has been evaluated as per guidelines (to be specified and is shown against the relevant disability in the table below:

S.No	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/Mental Disability (in%)
1.	Locomotor Disability	@	<u>Deaf & Dumb</u>	<u>profound / Heavy</u> <u>100%</u>
2.	Low vision	#		
3.	Blindness	Both Eyes		
4.	Hearing Impairment	£		<u>partial / (etc)</u>
5.	Mental Retardation	X		
6.	Mental illness	X		

(Please strike out the disabilities which are not applicable)

2. This above condition is progressive/non-progressive/likely to improve/not likely to improve.

3. Reassessment of disability is:

(i) ~~not necessary~~, (or)

(ii) is recommended/after _____ Years _____ months, and therefore this Certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left/Right/both arms/legs

e.g. Single eye/both eyes

€ e.g. Left/Right/both ears

nic

4. The applicant has submitted the following documents as proof of residence:-

Nature of Document	Date of issue	Details of authority issuing Certificate
<i>Attared</i>	<i>6.7.15</i>	<i>Dr. R. Mehanathan</i> <i>medical officer</i> <i>Govt. PHC. Thirumanur</i> <i>Singaram PH</i>

(Authorised Signatory of notified Medical Authority)

(Name and Seal)

Dr. R. Mehanathan
Dr. R. MEHANATHAN, M.B.B.S.,
Asst. Surgeon,
Regd. No: 51610,
Govt. PHC., Thirumanur.

Signature/Thumb
impression of the person
in whose favour Disability
certificate is issued.

Note:

In case this certificate is issued by a medical authority who is not a government servant, it shall be valid only if countersigned by the Chief Medical Officer of the District"

Note: The Principal rules were published in the Gazette of India vide notification number S.O.908(E), dated the 31st December, 1996

Form - IV
Disability Certificate
(In cases other than those mentioned in Forms II and III)

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:



JAYANTHI, MBBS, DLO
Reg. No: 56577,
ENT Specialist,
Assistant Surgeon
Tamil Nadu Medical Services

Certificate No.

Date:

This is to certify that I have carefully examined

Shri/Smt./Kum. K. SAVITHRI

son/wife/daughter of Shri N. KRISHNA Date of

Birth 11 09 1997 Age 18 years, ~~male~~/female FEMALE
(DD / MM / YY)

Registration No. 1316 permanent resident of House No. 33/6

Ward/Village/Street K.R. RAMASWAMY NAGAR Post-Office Anna Garden District

Chennai - 42 State Tamil Nadu whose photograph is affixed

above, and am satisfied that he/she is a case of Speech & Hearing Disability. His/her

extent of permanent physical impairment/disability has been evaluated as per guidelines

(to be specified) and is shown against the relevant disability in the table below:-

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both eyes		
4. ✓	Hearing Impaired	£	Bilateral SNHL	100 %
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months, and therefore
this certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left/Right/both arms/legs

e.g. Single eye/both eyes

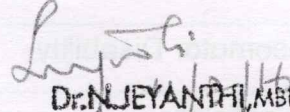
£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate
RATION CARD	JUN 2005	CS & EPD

K. சாவித்திரி.

Signature/Thumb Impression of the
Person in whose Favour disability
Certificate is issued


Dr. N. Jeyanthi, MBBS, DLO

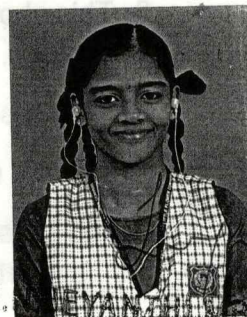
Reg. No. 56577
ENT Specialist,
Assistant Surgeon
(Authorized Signatory of notified Medical
Authority (Name and seal)
(Counter signature and seal of the
CMO/Medical Superintendent/Head of
Government Hospital, in case the
Certificate is issued by a medical authority
who is not a government servant (with
seal)

FORM - IV**Disability Certificate**

(In cases other than those mentioned in Forms II and III)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

(See rule 4)



DR. EYANTHI MBBS, DLO
REG NO: 56577
ENT SPECIALIST
ASSISTANT SURGEON
TAMILNADU MEDICAL SERVICES

Certificate No. _____

Date : _____

This is to certify that I have carefully examined the patient

Shri / Smt. / Kum. D. Rekhason / wife / daughter of Shri M. DhandapaniDate of Birth 30 10 1997 Age 15 years, Male / Female Female
(DD) (MM) (YY)Registration No. CHN/HI/01857 Permanent resident of House No. 14Ward / Village / K. K. Nagar Street Kannihapur^{am} Post Office _____District Chennai State Tamil Nadu

whose photograph is affixed above, and am satisfied that he/she is a case of Speech & Hearing disability, His/her extent of percentage physical impairment / disability has been evaluated as per guidelines (to be specified and is shown against the relevant disability in the table below :

S.No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment / Mental Disability (in%)
1.	Locomotor Disability	@		
2.	Low vision	#		
3.	Blindness	Both Eyes		
4.	Hearing Impairment	£	B/L Pwtd SNR	100%
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

2. This above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary, (or)

(ii) is recommended / after _____ years _____ months, and therefore this Certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left / Right / both arms / legs

e.g. Single eye / both eyes

£ e.g. Left / Right / both ears

4. The applicant has submitted the following documents as proof of residence:-

Nature of Document	Date of issue	Details of authority issuing Certificate

(Authorised Signatory of notified Medical Authority)

(Name and Seal)

DR.N.JEYANTHI,MBBS,DLO.

REG NO:56577

Countersigned

ENT SPECIALIST
ASSISTANT SURGEON
TAMILNADU MEDICAL SERVICES
Countersignature and seal of the
CMO / Medical Superintendent /
Head of Government Hospital, in
case the Certificate is issued
by a Medical Authority who is
not a government servant (with
seal))

D. Eja

Signature / Thumb
impression of the person in whose
favour Disability certificate is
issued.

Note : In case this certificate is issued by a medical authority who is not a government servant, it shall be valid only if countersigned by the Chief Medical Officer of the District"

Note : The principal rules were published in the Gazette of India vide notification number S.O. 908(E), dated the 31st December, 1996

Disability Certificate

State Resource Cum Training Centre for Differently Abled Persons,
K.K.Nagar, Chennai-78
(Unit of the Office of the Commissionerate for the Differently Abled, Chennai-6)



DR. N. JEYANTHI, MBBS, DLO,
REG NO: 56577
Date: ENT SPECIALIST,
ASSISTANT SURGEON
TAMIL NADU MEDICAL SERVICES

Certificate No. _____

This is to certify that I have carefully examined
Shri/Smt./Kum. K. Sowmiya
son/wife/daughter of Shri S. Karnan
Date of Birth 22. 11. 1997 Age 15 years, male/female
(DD / MM / YY)

Registration No. MDU / HI / 138 permanent resident of House
No. 6/3 Ward/Village/Street Sozhavanthar Road Post
Office CHECKANDORAI District MADURAI State TAMIL NADU

whose photograph is affixed above, and am satisfied that he/she is a case
of Speech & Hearing Disability. His/her extent of permanent physical
impairment/disability has been evaluated as per guidelines (to be specified) and
is shown against the relevant disability in the table below:-

Sl No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability			
2.	Low Vision			
3.	Blindness			
4.	Hearing Impaired	B/L Profound s/n		100%
5.	Mental Retardation			
6.	Mental Illness			

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months, and therefore

this certificate shall be valid till _____

(DD)

(MM)

(YY)

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate

K. Senthil Kumar

Signature / Thumb impression of the person
in whose favour disability certificate is issued

(Authorized Signatory of notified Medical Authority
(Name and seal))

DR.N.JEYANTHI.MBBS,DLO.

REG NO:56577

ENT SPECIALIS,

ASSISTANT SURGEON

TAMILNADU MEDICAL SERVICES

1879

REGIONAL MEDICAL BOARD

Govt. Kilpauk Medical College Hospital, Chennai -10.

MEDICAL REPORT

L. Dis. No. 7340 /RMB/2017

Dated.: 27.10.2017

Selvi. C.Sree kamakshi D/o Mr. K.Chandrasekaran 17 years. residing at No.4. Aswin Apartments, Mardavelipakkam, Chennai-28.

Identification Marks: -

1. Nil
2. Nil

OBSERVATION REPORT:

As per the opinion of Professor and Head of the Department of Psychiatry. she is suffering from Learning Disorder. History, Psychological assessment and Psychiatric Evaluation reveal that she has Mental Retardation.

She is recommended the following concessions during examination.


1. Exemption from Second Language Paper
2. Allocation of a scribe.

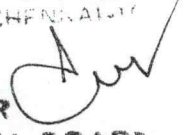
1. Dr. T.S. Meena., MD., DGO.,
(Prof. of O&G)

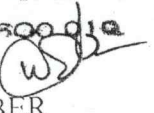
2. Dr. Angeline Selvaraj.,MS., Mch.,
(Prof. of Burns and Plastic Surgery)

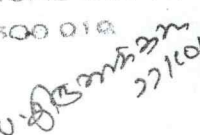
3. Dr. A. Chandrasekaran.,MD.,
(Prof. of Anaesthesiology)




CHAIRMAN
CHAIRMAN
REGIONAL MEDICAL BOARD
GOVT. K M C. H. CHENNAI-10


MEMBER
MEMBER
REGIONAL MEDICAL BOARD
CHENNAI - 600 019

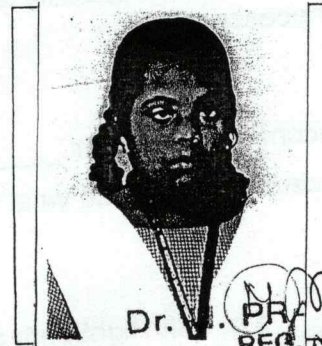

MEMBER
MEMBER
REGIONAL MEDICAL BOARD
CHENNAI - 600 019

for DEAN 
Govt. Kilpauk Medical College Hospital.
Chennai-10.

Form - IV
Disability Certificate

(In cases other than those mentioned in Forms II and III)

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:



Dr. V. PRADEEP, M.D.(PS)
REG. NO: 72863
CIVIL ASSISTANT SURGEON
INSTITUTE OF MENTAL HEALTH
KILPAUK, CHENNAI - 600 010.
carefully examined

Certificate No. 8050 / MR / 22

Date:

This is to certify that I have

Shri/Smt./Kum. SHANMATHI.M

son/wife/daughter of Shri K. MARIAPPAN Date of

Birth 02 11 1998 Age 19 years, male/female female

(DD / MM / YY)

Registration No. CHN / MR / 16111 permanent resident of House No. 36/1

Ward/Village/Street Adarjan mudali Street Post-Office Mandaveli District

CHENNAI State TAMILNADU whose photograph is affixed

above, and am satisfied that he/she is a case of Intellectual Disability. His/her

extent of permanent physical impairment/disability has been evaluated as per guidelines

(to be specified) and is shown against the relevant disability in the table below:-

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both eyes		
4.	Hearing Impaired	£		
5.	Mental Retardation	X	Mild Mental Retardation	60% (sixty)
6.	Mental Illness	X	IS = 50	

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :
(i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months, and therefore
this certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left/Right/both arms/legs

e.g. Single eye/both eyes

£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate
Aadhar card 8001 742)	03'9)	Govt. of India

Shanmugan M

Signature/Thumb Impression of the
Person in whose Favour disability
Certificate is issued

Dr. N. PRABHU, M.D.(PSY)

REG. No: 72863
(Authorized Signatory) Civil Assistant Surgeon
Authority (Name and Seal) HEALTH
INSTITUTE of Mental and Neuro Sciences
(Counter signature and seal of the
CMO/Medical Superintendent/Head of
Government Hospital; in case the
Certificate is issued by a medical authority
who is not a government servant (with
seal)

REGIONAL MEDICAL BOARD

Govt. Kilpauk Medical College Hospital, Chennai -10.

MEDICAL REPORT

L. Dis. No. 3054/RMB/2019

Dated.: 10.04.2019

Selvi. V.Sri Gayathri D/o S.V.Raman, No.29/12, Naidu Street, Mylapore, Chennai - 04.

Identification Marks: -

1.A Blackmole on Right arm.

OBSERVATION REPORT:

History, Neurological assessment and Neurological Evaluation reveal that She has **Learning Disorder** as per the opinion of Professor and Head of the Department of Psychiatry.

She is recommended the following concessions during examination.

1. Overlooking Spelling and Grammatical errors.
2. Additional time of One Hour for writing the examination.
3. Exemption from Second Language Paper -Tamil.

1. Dr. Angeline Selvaraj
(Prof. of Burns&Plastic Surgery)

CHAIRMAN
REGIONAL MEDICAL BOARD
GOVT. KILPAUK MEDICAL COLLEGE HOSPITAL
CHENNAI-10.

- Chairman

2. Dr. M.Geetha
(Prof. of O&G)

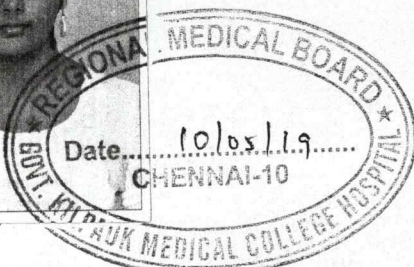
MEMBER
REGIONAL MEDICAL BOARD
GOVT. KILPAUK MEDICAL COLLEGE HOSPITAL
CHENNAI-10.

- Member

3. Dr. S.Balamurugan
(Prof. of Neurosurgery)

MEMBER
REGIONAL MEDICAL BOARD
GOVT. KILPAUK MEDICAL COLLEGE HOSPITAL
CHENNAI-10.

- Member



2.5.2019
DEAN

Govt.Kilpauk Medical College Hospital,
Chennai-10

REGIONAL MEDICAL BOARD + MEDICAL REPORT
Govt. Kilpauk Medical College Hospital, Chennai-10

L. Dis.No. 5015/RMB/KMCH/2015

Dated: 16.10.2015

As per the opinion of Professor and Head of the Department of Psychiatry
S4NJAN4 D/O Narasiman is 15 years No:71/73, 1st Main Road, Sathir Nagar, Sriram
Apartments, Adayar, Chennai-21. She is suffering from *Dyslexia*.

Identification Mark: 1. A black mole over left side of Chest.


OBSERVATION REPORT

History. Clinical evaluation, and Psychometry reveal that she has suffering
from Specific Learning Disorder (*Dyslexia*).
She may be given the following concessions during board examination:

- 1.Exemption from second language(*Tamil*).
- 2.Overlooking of spelling & Gramatical mistakes.
3. Usage of Calculator.
4. Extra time of one Hour.
- 5.Scribe for reading questions.
- 6.Exemption from practical examination.

1. Dr.Ravichandran. MD.,
(Professor of Rheumatology)

Prof. of


Chairman
CHAIRMAN
REGIONAL MEDICAL BOARD
GOVT. K. M. C. H. CHENNAI-10

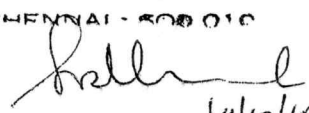
2. Dr.Raju. MD. M.S. D.Ortho
(Professor of Orthopedics)

Prof. of

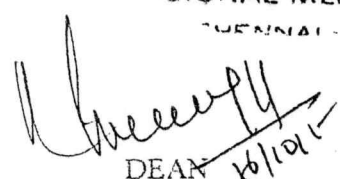

Member
MEMBER
REGIONAL MEDICAL BOARD
CHENNAI - 600 010

3. Dr. Vallisathyamoorthy.MD.
(Professor of Anaesthesia)

Prof. of


Member 14/10/15
MEMBER
REGIONAL MEDICAL BOARD
CHENNAI - 600 010




DEAN 16/10/15
Govt.Kilpauk Medical college Hospital
Chennai-10.
14/10/15

Psychological Report

5/9/15

Pt Name: Sanjana/15/F

OP NO: 3278/15

Ref for: LD and inattention assessment (ADHD)

This pt is a 15 yr old Tamil speaking female who has been referred from medical board for assessment. Comprehension, oriented and cooperative for the assessment. Able to understand the given instructions and follow the same. Attention could be aroused but ill-maintained at times.

Tests Administered:

- 1) Bender Gestalt visuomotor Test
- 2) Nimmhan Screening Index for dyslexia
- 3) Attention Deficit Hyperactivity Disorder Severity Rating Scale.

Test findings:

On assessment for LD, her verbal and vocabulary skills are upto her age level. Her written expression showed significantly poor handwriting, spelling error, articulation difficulty and Commission and omission of letters in the words. Her visuomotor gestalt function are adequately developed i articulation difficulty.

On assessment for ADHD, she showed moderate level of symptoms as fidgeting, impulsive speech, distracted attention are noted in her behavior.

Imp: The current psychometric evaluation of the pt. showed that she has severe level of specific learning disability in her written expression along with symptoms suggestive of Attention deficit hyperactivity disorder at a moderate level. She might be benefited from remedial assessment for her progress as she shows emotionally immature behavior pattern related to her overall behavior as attention seeking.

[Signature] 5/9/15

B. SUDHAKARAN, M.A., M.Phil (Cl. Psy.),
RCI Registration No: A07047
Assistant Professor of Psychology cum
Clinical Psychologist,
Institute of Mental Health, Chennai-10

1. ஊனத்தின் சான்றிதழ்
Disability Certificate

மருத்துவமனை/நிறுவனத்தின் பெயர் மற்றும் முகவரி
சான்றிதழ் எண் நாள்

Name & Address of the Institute / Hospital issuing the Certificate
Certificate No. Date

ஊனமுற்றோருக்கான மருத்துவச் சான்றிதழ்
Certificate for the Persons with Disabilities

திரு/திருமதி/செல்லி

த.பெ./க.பெ.

வயது

ஆண்/பெண் பதிவு எண் இவர்

பார்வையற்றவர்/உடல் ஊனமுற்றவர்/பேகம்திறன்/செவித்திறன்
குறையுடையவர் சதவிகிதம் (%) ஊனமுடையவர்

This is to certify that Shri/Smt/Kum M. DHANUVAARSAM
son/wife/daughter of P. MANIVASAGAM

Shri _____
Age _____ old male/female, Registration No. 23658 is
a case of C.R.

He/She is physically disabled / visual disabled / speech & hearing
disabled and has 60 % (Sight per cent)
permanent (physical impairment/visual impairment / Speech &
Hearing impairment) in relation to his/her

குறிப்பு

Note

1. ஊனத்தின் தன்மை முன்னேற்றம் அடையக் கூடியது / முன்னேற்றம்
அடைய முடியாதது / குணமடையக் கூடியது / குணமடைய முடியாதது.

This condition is progressive/ non-progressive/likely to improve
not likely to improve*

2. _____ மாதங்கள்/ ஆண்டுக்குப் பிறகு மறு மதிப்பீடு
செய்ய பரிந்துரைக்கப்பட்டது / பரிந்துரைக்கப்படவில்லை.

Re-assessment is not recommended / is recommended after
a period of _____ months/years*

* பொருத்தமில்லாதவற்றை அடிக்கவும்.

* Strikeout which is not applicable.

C.R. Dhanu
6

கையொப்பம்

(மருத்துவர்)

(முத்திரையுடன்)

(DOCTOR)

(Seal)

கையொப்பம்

(மருத்துவர்)

(முத்திரையுடன்)

(DOCTOR)

(Seal)

கையொப்பம்

(மருத்துவர்)

(முத்திரையுடன்)

(DOCTOR)

(Seal)

ஊனமுற்ற நபரின் கையொப்பம்/விரல் ரேகை
Signature / Thumb impression of the patient



சுணைக்கணிப்பாளர்/ தலைமை
அலுவலர்/மருத்துவமனையின்
மேலொப்பம்
Signed by the
Superintendent/CMO/Head
of (with Seal)

INDAR, M.B.B.S. D.Ortho
Regd No: 42416
Peripheral Hospital
Agar, Chennai-78

Rajiv Gandhi Govt General Hospital, Chennai-3.

Certificate No: 001523/RMB/RSCH/16

Held on: 22/1/2016

Certificate for the person with Learning Disabilities-LD

This is to certify that Mr/Mr/selvi NIKITHA RANKUMAR

S/o, D/o, W/o S. RANKUMAR

Aged 22 years, is a person suffering from Learning Disorder with specific impairment in Reading (dyslexia) / spelling / arithmetic / motor coordination. Since his/her condition results in a specific impairment of scholastic functioning he/she may be allowed the following concessions as permitted

1. Exemption from Tamil Language/ second language
2. Extra one hour for writing theory exam
3. Overlooking spelling mistakes
4. Using calculator
5. Allocation of a scribe



This condition is progressive/ non progressive

Likely to improve/ not likely to improve.

Reassessment is recommended / not recommended after a period of 3 months/years.

Prof. Poorna Chandrika
Member 22/1/2016
Prof. Poorna Chandrika
PSYCHIATRIST
SENIOR CIVIL SURGEON
RAJIV GANDHI GOVT. GENERAL HOSPITAL
CHENNAI-600 003
R. NIKITHA

Prof. N. R. Uvaraj
Member 22.1.16
Prof. N. R. UVARAJ
ORTHOSURGEON
SENIOR CIVIL SURGEON
RAJIV GANDHI GOVT. GENERAL HOSPITAL
CHENNAI-600 003

Prof. G.S. Chanthi
Chairman 22/1/16
Prof. G.S. CHANTHI
PHYSICIAN
SENIOR CIVIL SURGEON
RAJIV GANDHI GOVT. GENERAL HOSPITAL
CHENNAI-600 003

Signature/ thumb impression of the individual

Form - IV
Disability Certificate

(In cases other than those mentioned in Forms II and III)

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:



Certificate No. _____

Date: 21/7/2018

This is to certify that I have carefully examined
Shri/Smt./Kum. Pahawan

son/wife/daughter of Shri Ethimale Date of
Birth _____ Age 18 years, male/female _____

(DD / MM / YY)

Registration No. 211 permanent resident of House No. Vandani Nagar

Ward/Village/Street _____ Post-Office Revathi District
_____ State Revathi whose photograph is affixed

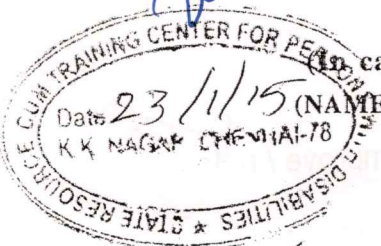
above, and am satisfied that he/she is a case of Low Vision Disability. His/her
extent of permanent physical impairment/disability has been evaluated as per guidelines
(to be specified) and is shown against the relevant disability in the table below:-

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#	RE Optician	
3.	Blindness	Both eyes	Refraction	
4.	Hearing Impaired	£		
5.	Mental Retardation	X		
6.	Mental Illness	X		

(Please strike out the disabilities which are not applicable)

Form-IV

DISABILITY CERTIFICATE



(In cases other than those mentioned in Form II and III)
 (NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING
 THE CERTIFICATE)

(See rule 4)



Certificate No. SRTC/MR/33

Date: 23/11/15
 Dr. V. JAT
 ASSISTANT

This is to certify that I have carefully examined

Shri/ Smt / Kum. R. Poov Raja Son / wife daughter of

Shri B. Ramesh

Date of Birth 16 04 98 Age 16 years, Male / female
 (DD / MM / YY)

Registration No. CHN/MR/46935 Permanent resident of House

No. 14 B Ward / Village / Street 6th main Rd Post Mandharshuram nagar

Office Velacherry District Chennai State Tamil Nadu 600 000

Whose photograph is affixed above, and am satisfied that he/she is a case of MENTAL RETARDATION disability. His / her extent of percentage physical impairment / disability has been evaluated as per guidelines (to be specified and is shown against the relevant disability in the table below.

S.No.	Disability	Affected part of Body	Diagnosis	Permanent physical impairment / Mental Disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both Eyes		
4.	Hearing Impairment	£		
5.	Mental Retardation	X	<u>mild to</u>	<u>41% (for one)</u>
6.	Mental Illness	X		

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary,

Or

(ii) is recommended/ after _____ years _____ months; and therefore this certificate shall be valid till _____

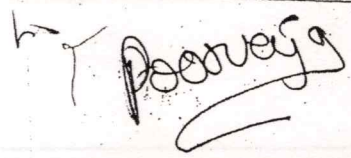
(DD)

(MM)

(YY)

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate



Signature/Thumb Impression of the Person in whose Favor disability Certificate is issued

23/1/2018
Reg No: 6411
Dr. V. JAIKUMAR, M.B.B.S., M.D. (P)
ASSISTANT PROFESSOR IN PSYCHIATRY
INSTITUTE OF MENTAL HEALTH

(Authorized Signatory of notified Medical Authority (Name and seal)

(Counter-signature and seal of the CMO/Medical Superintendent/Head Government Hospital, in case the Certificate is issued by a medical officer who is not a government servant (with seal)

Disability Certificate

State Resource Cum Training Centre for Differently Abled Persons,
K.K. Nagar, Chennai - 78
(Unit of the Office of the Commissionerate for the Welfare of the Differently
Abled, Chennai - 6)



Dr. M. GEMATHI SANKAR MBBS, DLS
Reg No 68191
ASSISTANT SURGEON
GOVT PERIPHERAL HOSPITAL
K K. NAGAR CHENNAI 78

Certificate No. SRIC/MR79

Date: 7/10/2011

This is to certify that I have carefully examined
Shri/Smt/Kum. S. Gita priya

son/wife/daughter of Shri B. Siva Kumar

Date of Birth 17 08 2000 Age 11 years, male/female F

(DD/MM/YY)

Registration No. CHN/MR/34997 permanent resident of House

No. 16A/30A Ward/Village/Street Ragavan Street Post

Office Vetri Nagar District CHENNAI-82 State Tamil Nadu

whose photograph is affixed above, and am satisfied that he / she is a case
of MENTAL Disability. His/her extent of permanent physical
impairment/disability has been evaluated as per guidelines (to be specified) and is
shown against the relevant disability in the table below :-

Sl. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment / mental disability (in%)
1.	Locomotor Disability			
2.	Low Vision			
3.	Blindness			
4.	Hearing Impaired			
5.	Mental retardation	Brain	20-50 Down's Syndrome	60%
6.	Mental Illness			

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary.

Or

(ii) is recommended / after _____ years _____ months, and therefore

this certificate shall be valid till

(DD)

(MM)

(YYYY)

4. The applicant has submitted the following document as proof of residence :-

Nature of Document	Date of Issue	Details of authority issuing certificate
Ration card	DEC - 2004	CSEPP

(Authorized Signatory of notified Medical Authority)

Dr. M. GOMATHI SANKAR MBBS

Reg No 68191 (Name and seal)

ASSISTANT SURGEON

GOVT PERIPHERAL HOSPITAL

K K. NAGAR CHENNAI - 78

S. Gita priya

Signature / Thumb impression of the person

Form - IV
Disability Certificate
(In cases other than those mentioned in Forms II and III)

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:



DR. S. SUJATHA
Reg. No. 61875
Assistant Surgeon
INSTITUTE OF MENTAL HEALTH
Chennai - 600 010

Certificate No. SRFE/MR/48

Date: 3/8/18

This is to certify that I have carefully examined
Shri/Smt./Kum. V. PREETHA VELAN

son/wife/daughter of Shri T. VELAN (V. ESWARI) Date of
Birth 18 07 1999 Age 19 years, male/female FEMALE

(DD / MM / YY)

Registration No. CHN/MR/4662 permanent resident of House No. 10/12

Ward/Village/Street LOOP STREET Post-Office C.I.T COLONY District
CH-4 MYLAPORE State TAMILNADU whose photograph is affixed
above, and am satisfied that he/she is a case of Mental **Disability**. His/her
extent of permanent physical impairment/disability has been evaluated as per guidelines
(to be specified) and is shown against the relevant disability in the table below:-

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor Disability	@		
2.	Low Vision	#		
3.	Blindness	Both eyes		
4.	Hearing Impaired	£		
5. ✓	Mental Retardation	X	Mild mental Retardation	Permanent 10-60
6.	Mental Illness	X		disability - 50%

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive / non-progressive / likely to improve / not likely to improve.

3. Reassessment of disability is :

(i) not necessary,

Or

(ii) is recommended/ after 10 years _____ months, and therefore this certificate shall be valid till _____
(DD) (MM) (YY)

@ e.g. Left/Right/both arms/legs

e.g. Single eye/both eyes

£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate
Aadhar Card 7614	9843 5592	Govt. of India.

v. Preetha Velan

Signature/Thumb Impression of the
Person in whose Favour disability
Certificate is issued

S. Sujatha.
Dr. S. SUJATHA
Reg. No. 61875
Civil Assistant Surgeon
INSTITUTE OF MENTAL HEALTH
Chennai - 600 010

(Authorized Signatory of notified Medical
Authority (Name and seal)
(Counter signature and seal of the
CMO/Medical Superintendent/Head of
Government Hospital, in case the
Certificate is issued by a medical authority
who is not a government servant (with
seal)

GOVERNMENTY PERIPHERAL HOSPITAL, K.K. NAGAR,
CHENNAI 78

IMPAIRMENT / DISABILITY CERTIFICATE

This certificate represents % of physical impairment and not valid for medico Legal

This is to certify that Thiru/Tmt/Selvan/Selvi G.R. VITAYA VARSHINI

Son of/ daughter of/ wife of Thiru. K. GOVINDARAJU

Aged 16 Years old male/ female OP / IP No. 9637/15

is a case of Right hemiparesis with mild weakness
of upper, lower limb

He / She is physically handicapped and has 65 % (severe
hemiparesis
permanent physical impairment / disability.



He / She is entitled for all allowances and concessions when the disability exceeds 40%

Identification marks

1. BBM & side neck
 2. BBM & kg
- V.R. G. G.R. VITAYA VARSHINI

Signature of the patient
(In case of minor, Signature
of Parent / Guardian along
with Name and Address.)

Seal



Medical Officer DR. K. REVENDAR, M.B.B.S., DORTHO
Medical Board for ORTHOPEDIC CIVIL SURGEON
Physically Challenged ORTHOPEDIC SURGEON
REGISTRATION No. 42416
GOVT. PERIPHERAL HOSPITAL
K.K. NAGAR, CHENNAI-600 078.