**Certificate of Disability**

Issuing Authority: [Mention Name of Clinic/Hospital]
Doctor Name: [Mention Name]
Address: [Mention Address]

Date:26-3-2019

**To whom it may concern**

Name: [patient name]

This is to certify that the undersigned have medically examined [mention name] s/o/d/o [mention name], father of [mention name] and have deduced the result from my observations through prescribed tests for proper diagnosis. He/she is Deaf and Dumb by birth. I have also examined mother of [Mention Name] named [Mention Name], aged[age].

**Diagnosis**: Patient has undergone through a detailed procedure of hearing and speech therapy and ENT specialist has carried out all the tests from which he diagnosed the hearing and speech disability. Furthermore, instruments like hearing aid is to be used for partial hearing that have been prescribed for daily usage for the patient’s ease. They help them in communicating their thoughts to other people.

**Duration of Disability:** By Birth

**Extent of Disability:** The extent to which it can affect the special person is the hinderance in recognising certain voices that are audible and inability to talk properly with people out there. Lack of proper communication would be the major issue which they will face in their daily lives.

**Limitations:** Their treatment would be limited to the ear drops and prescribed hearing aid devices that are operated by batteries. They can easily manage their understanding through those instruments.

Reports are being attached with this certificate for further assurance. Identification card copy is also attached for further inquiry.

All family members are resident of [locality name] [Mention address].

Notes:

* This condition is progressive/non-progressive/likely to improve/non-likely to improve.
* Reassessment is not recommended/recommended after a certain period of []months/years.

Signature: