FORM II

Medical Certificate for Deaf Candidate

Certified that, I, Dr. _____ Registration No. _____ have this _____day of 19 , examined the candidate whose particulars are given below :

1. Name of Candidate :
2. Father's Name :
3. Sex :
4. Approximate Age :
5. Identification mark :
6. An estimate of the residual hearing, if any and the basis on which this estimate has been arrived at.
   (i) Right ear
   (ii) Left ear

7. Onset of deafness (Please state whether deafness is from birth of acquired later. If it has been caused afterwards the age and cause of deafness may be indicated).

   (for the purpose of concessions granted to deaf candidates, deaf are those in whom the sense of hearing is non- functional for the ordinary purposes of life. Generally loss of hearing at 60 decibels or above at 500, 1000, 2000 frequencies will make residual hearing non-functional).

8. Please state clearly whether the candidate is deaf for the purpose of giving concessions granted by the Board to deaf candidates :

9. Please enclose Audio-grarn chart.

Signature of candidate:
Place:
Date:

(Signature of E.N.T. Specialist)
Designation:
Office Stamp:
Address: