Medical Superintendent Office
All India Institute of Medical Sciences, Jodhpur

Disability Application Form

Filled by Patient / Attendant: -

Name : - _____**Sex: -**___

Date of Birth : - ____ /____ /____ **Age: -**___

Father's/ Husband's Name : - _____

Mobile No. : - _____&_____

Hospital Id : - _____

Address : - _____

_____

I hereby certify that the information provided above is true and correct.

Date: __/__/_____ **Signature: -** Patient / Attendant

Filled by Consultant: -

Consultant Name : - _____

Department : - _____

Nature of Disability : - _____

Other Departments that may be required for evaluation: - (1) _____

(2) _____

(3) _____

Verified by Consultant (with signature and seal) : - _____