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གསོ་བ་ལྷན་ཁག།

ROYAL GOVERNMENT OF BHUTAN
Ministry of Health



Reg. No.....

DISABILITY CERTIFICATE

I certify that I have examined

Full name.....
Age/Sex bearing Citizenship ID /Passport /Voter card No. on
(date)..... who is employed asin
..... (Agency)

In my opinion:

A. CAUSE OF INJURY / ILLNESS: (tick appropriate cage):

- (a) Related to work (b) Not related to work (c) Of uncertain cause (comment):

B. NATURE OF DISABILITY* (tick appropriate cage):

- (a) Temporary partial: (b) Temporary total: (c) Permanent partial (d) Permanent total:

C. FITNESS FOR WORK (Tick those boxes which apply):

- (a) Fit to return to pre-injury duties, no further treatment required;
- (b) Fit to return to pre-injury duties, but requires further treatment;
- (c) Fit to return to work for restricted hours/days from: to
- (d) Fit to return to work on restricted duties from:
- Avoid prolonged standing/ walking/ sitting;
 - Avoid squatting/ kneeling/ ladders/ steps;
 - No lifting of heavy of objects;
 - Avoid repetitive use of affected body part;
 - Avoid repetitive bending/ lifting;
 - Other:
- (e) Unfit to work for
- (f) Unfit for present work

Signature of Treating Practitioner:.....
Name:..... Designation:
BMHC Reg. No.: Health Centre:
Date (certificate is signed): Official Seal:.....

Endorsement by Board of Medical Doctors:

After having discussed the patient's illness and medical interventions with the treating practitioner, we hereby endorse the opinion expressed by the treating practitioner.

Signatures of:

..... Board member 1 Name: Designation: BMHC Reg. No. Board member 2 Name: Designation: BMHC Reg. No. Board member 3 Name: Designation: BMHC Reg. No.
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