SOCIAL WELFARE DIVISION

DISABILITY ASSISTANCE

MEDICAL OFFICER'S REPORT

Local Board ..................................................
Address .................................................
Date ......................................................

THE DISTRICT MEDICAL OFFICER

CLINIC/HEALTH CENTRE ........................................

Kindly provide a Medical Report for the purpose of Disability Assistance.

.................................................. Social Welfare Adviser

Name of Applicant ..........................................................
I.D. No. ..................................................................
Address ..................................................................
Nature of Disability ....................................................
Whether Disabled from earning ................................ Percentage of disability ..................................
Whether Disability is Permanent ........................................

.................................................. Date .................................................. Medical Officer

(Kindly affix your office stamp)

Note to Medical Officer—The object of this Report is to target persons who are mentally or physically handicapped with a disability that is permanent or likely to be permanent.

G.P., Tr./To.—Q 2840—40,000—/60