WP/SSD/SA/**MR**

Medical Report

Director of Social Services (W.P)/ Divisional Secretary

.....

Name :- .....

Age : -.....

The above named person was examined by me on ..... (date) and diagnosed him / her suffering from ..... (disability/illness).

I will recommend him / her an artificial lower limb / artificial upper limb / caliper shoes / white cane / walking stick / pair of crutches / forearm crutches / eye lens / folding wheel chair / wheel chair with a commode / special wheel chair / tricycle / spectacles / hearing aid / Braille Machine/ walker / hydro Mattress / air mattress / Financial aid.

....

Date Doctors signature and seal

Note :- A person certified as a low income person by the Grama Niladari of the living area is eligible for the above facility.