



MINISTRY OF HEALTH & FAMILY WELFARE, GOVERNMENT OF INDIA
THE PREVENTION OF ABUSE AND NEGLECT OF THE PERSONS WITH DISABILITIES ACT, 1989

Form No. _____
 Date: _____
 Name of the Person: _____
 Address: _____
 Signature: _____

1. Name of the Person: _____
 2. Age: _____
 3. Sex: _____
 4. Date of Birth: _____
 5. Date of Admission: _____
 6. Date of Discharge: _____
 7. Name of the Doctor: _____
 8. Name of the Nurse: _____
 9. Name of the Attendant: _____
 10. Name of the Ward: _____

No.	Name of the Person	Age	Sex	Date of Birth	Date of Admission	Date of Discharge	Name of the Doctor	Name of the Nurse	Name of the Attendant	Name of the Ward
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Signature of the Doctor: _____
 Signature of the Nurse: _____
 Signature of the Attendant: _____

Signature of the Person: _____

Signature of the Ward: _____

Signature of the Hospital: _____

Signature of the District: _____

Signature of the State: _____

Signature of the Union: _____

Signature of the Country: _____

Signature of the World: _____

Signature of the Universe: _____

Signature of the Cosmos: _____

Signature of the Galaxy: _____

Signature of the Planet: _____

Signature of the Moon: _____

Signature of the Sun: _____

Signature of the Stars: _____

Signature of the Planets: _____

Signature of the Galaxies: _____

Signature of the Universe: _____

Signature of the Cosmos: _____

Signature of the Galaxy: _____

Signature of the Planet: _____