[Appendix No.1] (Front page)

Disability Assessment Certificate for the National Pension

※ Please complete the form and check (√) the applicable boxes after referring to the notes & guidelines on the back of this form.

Patient's personal information	Name:		Resident registration number:
	Tel (home):		Cell phone:
	Address:		

Classification of disability	Type/Site	Type:	Site:
	Causative disease		

Clinical course	Date of onset	Day . Month . Year .	Day . Month . Year .
	Date of first medical evaluation	Day . Month . Year .	Day . Month . Year .
	Date of full recovery	Day . Month . Year .	Day . Month . Year .

Treatments and disability or condition	※ Please describe the disability and the major treatments. Test results and treatments (treatment duration, history, surgery type, surgery date, dialysis start date, etc.) up to the present time as well as any clinical symptoms and disabilities need to be described in detail in the "Medical Assessment of Disability" section.

Pre-existing disability (same site)	Yes □ No □	Onset	Day . Month . Year .	Type and level	

Outlook for disability	Ability to perform dailyroutine activities or job-related tasks			Comments	
	Possibility of any changes?	Yes □ No □	Please state the reasonfor changes		

I diagnosed the disabilityor condition described above.

Day Month Year

Facility:

Location:

Facility's license number:

Official seal

Physician's name(print): (Signature)

Physician's license number:

Physician's board number:

Medical specialty:

210mm×297mm [General paper, 60g/m²(recycled materials)]

เอกสารแ

[Appendix No.4]

Medical Assessment of Disability
(Paralysis)

<table>
<tr><td>Patient's name</td><td colspan="2"></td><td>Resident registration number</td><td colspan="2">-</td></tr>
<tr><td rowspan="3">Paralysis</td><td>Lesion location</td><td colspan="4">brain, spinal cord, peripheral nerve, muscles, others</td></tr>
<tr><td>Paralysis type</td><td colspan="4">Sensory paralysis, motor paralysis</td></tr>
<tr><td>Others</td><td colspan="4">Bowel, bladder dysfunction: If yes (voluntary / involuntary control), No ( )
If yes (voluntary / involuntary control), No ()
Involuntary bladder control: Continuous catheterization ( ), Intermittent catheterization (times/day),
Other type ( )</td></tr>
<tr><td rowspan="8">Vegetative state
※Check (V) applicable symptoms</td><td colspan="4">Symptoms</td><td>Applicable</td></tr>
<tr><td colspan="4">1. No evidence of sustained, reproducible, purposeful, or voluntary behavioral responses to visual, auditory, tactile, or noxious stimuli.</td><td></td></tr>
<tr><td colspan="4">2. No evidence of awareness of self or environment and an inability to interact with others.</td><td></td></tr>
<tr><td colspan="4">3. No evidence of language comprehension or expression.</td><td></td></tr>
<tr><td colspan="4">4. Bowel and bladder incontinence.</td><td></td></tr>
<tr><td colspan="4">5. Intermittent wakefulness manifested by the presence of sleep wake cycles.</td><td></td></tr>
<tr><td colspan="4">6. Variably preserved cranial-nerve reflexes and spinal reflexes</td><td></td></tr>
<tr><td colspan="5">※ Notes: Cases more severe than the described criteria are also applicable in No. 5 and No. 6.</td></tr>
<tr><td colspan="2">Hoehn and Yahr scale results</td><td colspan="4"></td></tr>
<tr><td rowspan="2">Disability level in daily activities</td><td colspan="3">Wash face:
Wring towels:
Tie strings:
Don and doff tops:
Grasp(can open newspapers): Right: Left:
Hold (can clench and open a magazine): Right: Left:
Eat with a spoon: Right: Left:
Touch face with palm: Right: Left:
Unzip front zipper of pants: Right : Left:
Put hand on buttock: Right: Left:
Fasten small buttons: Right: Left:</td><td colspan="2">Stand up:
Walk:
Climb stairs:
Descend stairs:
Ride public transportation (subway):
Stand on one leg: Right: Left:
※ Rating criteria (with no assistive devices):
5: Complete independence
4: Supervision required
3: Moderate assistance required
2: Maximal assistance required
1: Total dependence</td></tr>
<tr><td colspan="5">Use of assistive devices: Always / When needed / Not required   Assistive device type:</td></tr>
</table>

Degree of muscle strength of upper and lower extremities MMT (6 grades)	Upper extremities			Lower extremities		
	Classification	Right	Left	Classification	Right	Left
	Shoulder joint			Hip joint		
	Elbow joint			Knee joint		
	Wrist joint			Ankle joint		
	※ Rating criteria: Normal: N Good: G Fair: F Poor: P Trace: T Zero: Z					

Other findings and comments	
	For cases of speech disturbance, please circle the applicable items. 1. Everybody can understand his/her everyday conversation. 2. Family members can understand speech over the telephone, others cannot. 3. Family members can understand everyday conversation, others cannot. 4. Nobody can understand everyday conversation.
	Motor aphasia ( ), Sensory aphasia ( ), Global aphasia ( ), Others ( )

※ Please attach all relevant records (test results, medical records, etc.).

Day Month Year

Name of facility:. Physician's license number: Physician's name (print): (Signature)