

Form-V
Certificate of Disability

(In cases of amputation or complete permanent paralysis of limbs or dwarfism and
in case of blindness)

[See rule 18(1)]

(Name and Address of the Medical Authority issuing the Certificate)

Recent passport size
attested photograph

(Showing face only) of the
person with disability.

Certificate No. _____

Date: _____

This is to certify that I have carefully examined Shri/Smt./Kum.
_____ son/wife/daughter of Shri _____ Date of
Birth (DD/MM/YY) _____ Age _____ years, male/female _____
registration No. _____ permanent resident of House No. _____
Ward/Village/Street _____ Post Office _____ District
_____ State _____, whose photograph is affixed above, and am
satisfied that:

(A) he/she is a case of:

- locomotor disability
 - dwarfism
 - blindness
- (Please tick as applicable)

(B) the diagnosis in his/her case is _____

(A) he/she has _____ % (in figure) _____ percent (in words)
permanent locomotor disability/dwarfism/blindness in relation to his/her _____
(part of body) as per guidelines (.....number and date of issue of the guidelines
to be specified).

2. The applicant has submitted the following document as proof of residence:-

| Nature of Document | Date of Issue | Details of authority issuing certificate |
|--------------------|---------------|--|
| | | |

(Signature and Seal of Authorised Signatory of
notified Medical Authority)

Signature/thumb
impression of the
person in whose
favour certificate of
disability is issued

Form - VI

Certificate of Disability

(In cases of multiple disabilities)

[See rule 18(1)]

(Name and Address of the Medical Authority issuing the Certificate)

Recent passport
size attested
photograph

(Showing face only)
of the person with
disability.

Certificate No. _____

Date: _____

This is to certify that we have carefully examined Shri/Smt./Kum.
_____ son/wife/daughter of Shri
_____ Date of Birth (DD/MM/YY) _____ Age
_____ years, male/female _____.

Registration No. _____ permanent resident of House No. _____
Ward/Village/Street _____ Post Office _____ District _____ State
_____, whose photograph is affixed above, and am satisfied that:

(A) he/she is a case of Multiple Disability. His/her extent of permanent physical impairment/disability has been evaluated as per guidelines (.....number and date of issue of the guidelines to be specified) for the disabilities ticked below, and is shown against the relevant disability in the table below:

| S. No | Disability | Affected part of body | Diagnosis | Permanent physical impairment/mental disability (in %) |
|-------|--------------------------------|-----------------------|-----------|--|
| 1. | Locomotor disability | @ | | |
| 2. | Muscular Dystrophy | | | |
| 3. | Leprosy cured | | | |
| 4. | Dwarfism | | | |
| 5. | Cerebral Palsy | | | |
| 6. | Acid attack Victim | | | |
| 7. | Low vision | # | | |
| 8. | Blindness | # | | |
| 9. | Deaf | £ | | |
| 10. | Hard of Hearing | £ | | |
| 11. | Speech and Language disability | | | |
| 12. | Intellectual Disability | | | |

| | | | | |
|-----|---------------------------------|--|--|--|
| 13. | Specific Learning Disability | | | |
| 14. | Autism Spectrum Disorder | | | |
| 15. | Mental illness | | | |
| 16. | Chronic Neurological Conditions | | | |
| 17. | Multiple sclerosis | | | |
| 18. | Parkinson's disease | | | |
| 19. | Haemophilia | | | |
| 20. | Thalassemia | | | |
| 21. | Sickle Cell disease | | | |

(B) In the light of the above, his/her over all permanent physical impairment as per guidelines (.....number and date of issue of the guidelines to be specified), is as follows :-

In figures : - ----- percent

In words :- ----- percent

2. This condition is progressive/non-progressive/likely to improve/not likely to improve.

3. Reassessment of disability is :

(i) not necessary,
or

(ii) is recommended/after years months, and therefore this certificate shall be valid till -----

(DD) (MM) (YY)

@ e.g. Left/right/both arms/legs

e.g. Single eye

£ e.g. Left/Right/both ears

4.The applicant has submitted the following document as proof of residence:-

| Nature of document | Date of issue | Details of authority issuing certificate |
|--------------------|---------------|--|
| | | |

5. Signature and seal of the Medical Authority.

| | | |
|---|-------------------------|----------------------------------|
| | | |
| Name and Seal of Member | Name and Seal of Member | Name and Seal of the Chairperson |
| Signature/thumb impression of the person in whose favour certificate of disability is issued. | | |

Form – VII
 Certificate of Disability
 (In cases other than those mentioned in Forms V and VI)
 (Name and Address of the Medical Authority issuing the Certificate)
 (See rule 18(1))

| |
|---|
| Recent passport size attested photograph (Showing face only) of the person with disability |
|---|

Certificate No. _____

Date: _____

This is to certify that I have carefully examined

Shri/Smt/Kum _____ son/wife/daughter of
 Shri _____ Date of Birth (DD/MM/YY) _____
 _____ Age _____ years, male/female _____ Registration No.
 _____ permanent resident of House No. _____ Ward/Village/Street
 _____ Post Office _____ District _____ State
 _____, whose photograph is affixed above, and am satisfied that
 he/she is a case of _____ disability. His/her extent of
 percentage physical impairment/disability has been evaluated as per guidelines
 (.....number and date of issue of the guidelines to be specified) and is shown against
 the relevant disability in the table below:-

| S. No | Disability | Affected part of body | Diagnosis | Permanent physical impairment/mental disability (in %) |
|-------|--------------------------------|-----------------------|-----------|--|
| 1. | Locomotor disability | @ | | |
| 2. | Muscular Dystrophy | | | |
| 3. | Leprosy cured | | | |
| 4. | Cerebral Palsy | | | |
| 5. | Acid attack Victim | | | |
| 6. | Low vision | # | | |
| 7. | Deaf | € | | |
| 8. | Hard of Hearing | € | | |
| 9. | Speech and Language disability | | | |
| 10. | Intellectual Disability | | | |
| 11. | Specific Learning Disability | | | |
| 12. | Autism Spectrum Disorder | | | |
| 13. | Mental illness | | | |

| | | | | |
|-----|---------------------------------|--|--|--|
| 14. | Chronic Neurological Conditions | | | |
| 15. | Multiple sclerosis | | | |
| 16. | Parkinson's disease | | | |
| 17. | Haemophilia | | | |
| 18. | Thalassemia | | | |
| 19. | Sickle Cell disease | | | |

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive/non-progressive/likely to improve/not likely to improve.

3. Reassessment of disability is:

(i) not necessary, or

(ii) is recommended/after _____ years _____ months, and therefore this certificate shall be valid till (DD/MM/YY) ____ _

@ - eg. Left/Right/both arms/legs

- eg. Single eye/both eyes

€ - eg. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

| Nature of document | Date of issue | Details of authority issuing certificate |
|--------------------|---------------|--|
| | | |

(Authorised Signatory of notified Medical Authority)
(Name and Seal)

Countersigned
{Countersignature and seal of the
Chief Medical Officer/Medical Superintendent/
Head of Government Hospital, in case the
Certificate is issued by a medical authority who is
not a Government servant (with seal)}

| |
|--|
| Signature/thumb impression of the person in whose favour certificate of disability is issued |
|--|

Note.- In case this certificate is issued by a medical authority who is not a Government servant, it shall be valid only if countersigned by the Chief Medical Officer of the District