

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
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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 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 Multiple 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) for the disabilities ticked below and is shown against the relevant disability in the table below:-

Sl. 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	Language Speech and 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. The 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

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

Nature of document	Date of issue	Details of authority issuing certificate

4. 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
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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:-

Sl. 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	Language Speech and 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

3. 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
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Note: In case this certificate issued by medical authority who is not a Government servant , it shall be valid only if counter sign by Chief Medical Officer of the District.

FORM - VIII

[Intimation of rejection of Application for Certificate of Disability]

[See rule 18 (4)]

No. _____ Dated :

To,

(Name and address of applicant
for Certificate of Disability)

Sub: Rejection of Application for Certificate of Disability

Sir/ Madam,

Please refer to your application dated _____ for issue of a Certificate of Disability
for the following disability: _____

2. Pursuant to the above application, you have been examined by the undersigned/
Medical Authority on _____, and I regret to inform that, for the reasons mentioned
below, it is not possible to issue a Certificate of Disability in your favour:

- (i)
- (ii)
- (iii)

3. In case you are aggrieved by the rejection of your application, you may represent
to _____, requesting for review of this decision.

Yours faithfully,
(Authorised Signatory of the notified Medical Authority)
(Name and Seal)