**Form - II**

# Disability Certificate

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

NAME AND ADDRESS OF THE
MEDICAL AUTHORITY
ISSUING THE CERTIFICATE:

Certificate No. Date:

This is to certify that I have carefully examined Shri/Smt./Kum.______________________________________________
son/wife/daughter of Shri.__________________________________________ Date of Birth ____ ____ ________ Age _______ years, male/female______
(date) (month) (year)
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 ☐ Blindness
(Please tick as applicable)

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

(1) He/She has .............% (in figure)................................................percent (in words) permanent physical Impairment/blindness in relation to his/her-------- (part of body) as per 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/Thumb Impression of the Person in whose Favour disability Certificate is issued**

**(Signature and seal of authorized Signatory of notified Medical Authority)**

GCP--410-6--4,00,000 Cps.--24-9-2014 {HCL-11}