

FORM-I

Disability Certificate

(In cases of amputation or complete permanent paralysis of limbs and in cases of blindness)
(Prescribed proforma subject to amendment from time to time)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

Recent PP 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
- Blindness

(Please tick as applicable)

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

(A) 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 documents 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 disability
certificate is
issued.

FORM - II
Disability Certificate
(In case of multiple disabilities)
(Prescribed proforma subject to amendment from time to time)
(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

Recent PP 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 are 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 (to be specified) for the disabilities ticked below, and shown against the relevant disability in the table below :

Sr. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1	Locomotor disability	@		
2	Low vision	#		
3	Blindness	Both Eyes		
4	Hearing impairment	£		
5	Mental retardation	X		
6	Mental-illness	X		

(B) In the light of the above, his/her over all permanent physical impairment as per 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 / both eyes

£ - e.g. Left / Right / both ears

4. The applicant has submitted the following documents 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 Chairperson

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

FORM - III
Disability Certificate

(In cases other than those mentioned in Form I and II)
(Prescribed proforma subject to amendment from time to time)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

Recent PP 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 (to be specified) and is shown against the relevant

disability in the table below :

Sr. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1	Locomotor disability	@		
2	Low vision	#		
3	Blindness	Both Eyes		
4	Hearing impairment	£		
5	Mental retardation	X		
6	Mental-illness	X		

(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) _____

@ - e.g. Left/Right/both arms/legs

- e.g. Single eye / both eyes

£ - e.g. Left / Right / both ears

4. The applicant has submitted the following documents 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
CMO/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 disability
certificate is issued.