

**Form-V**

**CERTIFICATE OF DISABILITY**

**(In cases of amputation or complete permanent paralysis of limbs or dwarfism and  
incase 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/YYYY) 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).

**1. 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 Authorized Signatory of  
Notified Medical Authority)

Signature/thumb  
impression of  
the person in  
whose favour

**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/YYYY) Age \_\_\_\_\_  
 \_\_\_\_\_ years, male/female \_\_\_\_\_ registration No. \_\_\_\_\_ permanent  
 resident of House No. \_\_\_\_\_ Ward/Village/Street \_\_\_\_\_ Post Office  
 \_\_\_\_\_ District \_\_\_\_\_ State \_\_\_\_\_, whose photographs  
 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 therelevant 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	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/YYYY.

@ 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

## Form-VII

## CERTIFICATE OF DISABILITY

(In cases other than those mentioned in Forms V and VI) [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/YYYY) 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	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/YYYY.

@ 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

5. Signature and seal of the Medical Authority.

Name and Seal of Member	Name and Seal of Member	Name and Seal of the Chairperson

(Authorized Signatory of Notified Medical Authority)

(Name & 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

**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.