Form-II

Disability Certificate
(In cases of amputation or complete permanent paralysis of limbs
and in cases of blindness)
(See rule 4)

(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____________________
(DD / MM / YY)
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 document as proof of residence:

<table>
<thead>
<tr>
<th>Nature of Document</th>
<th>Date of Issue</th>
<th>Details of authority issuing certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

Disability Certificate
(In case of multiple disabilities)
(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)
(See rule 4)

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 _____ _____ Age _____ years, male/female
(DD) (MM) (YY)
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:
<table>
<thead>
<tr>
<th>S. No.</th>
<th>Disability</th>
<th>Affected Part of Body</th>
<th>Diagnosis</th>
<th>Permanent physical impairment/mental disability (in %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Locomotor disability</td>
<td>@</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Low vision</td>
<td>#</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Blindness</td>
<td>Both Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Hearing impairment</td>
<td>£</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Mental retardation</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Mental-illness</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Nature of Document</th>
<th>Date of Issue</th>
<th>Details of authority issuing certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Signature and seal of the Medical Authority.

<table>
<thead>
<tr>
<th>Name and seal of Member</th>
<th>Name and seal of Member</th>
<th>Name and seal of the Chairperson</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Disability Certificate
(In cases other than those mentioned in Forms II and III)

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)
(See rule 4)

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__________________________

(DD) (MM) (YY)

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:-

<table>
<thead>
<tr>
<th>Recent PP size</th>
<th>Attested Photograph</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Showing face only) of the person with disability</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Disability</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Locomotor disability</td>
</tr>
<tr>
<td>2</td>
<td>Low vision</td>
</tr>
<tr>
<td>3</td>
<td>Blindness</td>
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<td>4</td>
<td>Hearing impairment</td>
</tr>
<tr>
<td>5</td>
<td>Mental retardation</td>
</tr>
<tr>
<td>6</td>
<td>Mental-illness</td>
</tr>
</tbody>
</table>

(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 document as proof of residence:
<table>
<thead>
<tr>
<th>Nature of Document</th>
<th>Date of Issue</th>
<th>Details of authority issuing certificate</th>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

(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

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.

Note: The principal rules were published in the Gazette of India vide notification number S.O. 908(E), dated the 31st December, 1996.