FORM-I

Certificate of Disability

(In cases of amputation or complete permanent paralysis of limbs or dwarfism 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 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 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

Certificate of Disability

(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 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 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	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 / YY) _____

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

 # - e.g. Single eye

£ - 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

Certificate of Disability

(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 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 :

Sr. 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 / 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.