

DISABILITY CERTIFICATE FORMAT - II

{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)**

No. - _____

Date - ____/____/____

Signature/LTI/RTI of the Candidate

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Passport size photograph of the candidate
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This is to certify that I have carefully examined Shri/Smt./Kum. _____,

son/wife/daughter of Shri _____ Date of Birth ____/____/____

[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

1. he/she is a case of (Please tick as applicable):

a. locomotor disability

b. blindness

2. The diagnosis in his/her case is _____.

3. 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).

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

Nature of Document	Date of Issue	Details of authority issuing the certificate

Official Seal:**[Authorized Signatory of notified Medical Authority] Name:**

DISABILITY CERTIFICATE FORMAT - III

{In cases of multiple disabilities}**(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)**

No. - _____

Date - ____/____/____

Signature/LTI/RTI of the Candidate

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Passport size photograph of the candidate
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This is to certify that I have carefully examined Shri/Smt./Kum. _____,

son/wife/daughter of Shri _____ Date of Birth ____/____/____

[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

1. 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:

S. 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		

Contd.

2. In the light of the above, his/her overall permanent physical impairment as per guidelines (to be specified), is as follows:

In figures: _____%

In words: _____percent

3. The above condition is progressive/ non-progressive/ likely to improve/ not likely to improve.

4. 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

5. The applicant has submitted the following document as proof of residence:

Nature of Document	Date of Issue	Details of authority issuing the certificate

6. Signature and seal of the Medical Authority:

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

DISABILITY CERTIFICATE FORMAT - IV

{In cases of any other case not covered in Format – II & III}**(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)**

No. - _____

Date - ____/____/____

Signature/LTI/RTI of the Candidate

 Passport size
 photograph
 of the
 candidate

This is to certify that I have carefully examined Shri/Smt./Kum. _____,

son/wife/daughter of Shri _____ Date of Birth ____/____/____

[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

1. 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:

S. 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		

Contd.

2. In the light of the above, his/her overall permanent physical impairment as per guidelines (to be specified), is as follows:

In figures: _____%

In words: _____percent

3. The above condition is progressive/ non-progressive/ likely to improve/ not likely to improve.

4. 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

5. The applicant has submitted the following document as proof of residence:

Nature of Document	Date of Issue	Details of authority issuing the certificate

Official Seal:

[Authorized Signatory of notified Medical Authority*]

Name: _____

* 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.

Countersigned

Official Seal:

[CMO/Medical Superintendent/Head of Govt. Hospital]

Name: _____

^ Countersignature and seal of the CMO/Medical Superintendent/Head of Government Hospital is essential in case the certificate is issued by a medical authority who is not a government servant.