

DISABILITY CERTIFICATE
(IN CASE 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)

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 _____
Date of Birth _____ Age _____ years, Male/Female _____
Registration No. _____ permanent resident of Home 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 _____

(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: -

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 disability certificate is issued.

DISABILITY CERTIFICATE
(In case other than those mentioned in Forms II)

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

(See rule 4)

Passport Size Attested Photograph showing photo of
--

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 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) for the disabilities (to be specified) and is shown against the relevant disability in the table below: -

S.No	Disability	Affected part of the body	Diagnosis	Permanent physical impairment/mental disabilities (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 progress/non progress/likely to improve/not likely to improve.

3. Reassessment of disability is:

(i) not necessary

Or

(ii) is recommended/after _____ years _____ on this, and therefore this certificate shall be valid till _____
(DD) (MM) (YY)

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

Nature of Document	Date of issue	Details of authority issuing certificate

(Authorized Signatory of notified Medical Authority)

(Name and Seal)