

**Certificate of Disability**

(In cases of amputation or complete permanent paralysis of limbs and in cases 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/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 .....

(C) 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 document as proof of residence: -

Nature of Document	Date of Issue	Details of authority issuing certificate

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

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

**Certificate of Disability**  
(In case 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)/(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 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 (.....number and date of issue of the  
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.	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 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 issued.

## Certificate of Disability

(In cases other than those mentioned in Forms V and VI)

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

[See rule 18(1)]

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 (to be specified) and is 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.	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			

(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)
    - @ - 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

(Authorised Signatory of notified Medical Authority)  
(Name and 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 disability is issued.
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**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 by Ministry of Social Justice and Empowerment vide notification number 489, dated 15.06.2017.