Proforma IV - A

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

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 document 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 certificate of disability certificate is issued

Proforma IV - B

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 only face) 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.

Proforma IV - C

Certificate of Disability

(In cases other than those mentioned in Forms A and B)

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

[See rule 18(1)]

Recent Passport size Attested photograph Showing only the face 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			
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

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.