

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.