

**Form-V
Certificate of Disability**

(In cases of amputation or complete permanent paralysis of limbs or dwarfism and in case 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 and Seal of Authorised Signatory of notified Medical Authority)

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

Form - VI
Certificate of Disability
(In cases 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 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:

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.

Form – VII
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

(.....number and date of issue of the 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.	Cerebral Palsy			
5.	Acid attack Victim			
6.	Low vision	#		
7.	Deaf	€		
8.	Hard of Hearing	€		
9.	Speech and Language disability			
10.	Intellectual Disability			
11.	Specific Learning Disability			
12.	Autism Spectrum Disorder			
13.	Mental illness			
14.	Chronic Neurological Conditions			
15.	Multiple sclerosis			

16.	Parkinson's disease			
17.	Haemophilia			
18.	Thalassemia			
19.	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

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

Certificate regarding physical limitation in an examinee to write

This is to certify that, I have examined Mr/Ms/Mrs _____ (name of the candidate with disability), a person with _____ (nature and percentage of disability as mentioned in the certificate of disability), S/o / D/o _____ a resident of _____ Village/District/State) and to state that he/ she has physical limitation which hampers his/ her writing capabilities owing to his/ her disability.

Signature

Chief Medical Officer/ Civil Surgeon/ Medical Superintendent of a
Government health care institution

Name & Designation

Name of Government Hospital/ Health Care Centre with Seal

Place:

Date:

Note: Certificate should be given by a specialist of the relevant stream/ disability (e.g. Visual impairment-Ophthalmologist, Locomotor disability-Orthopaedic specialist/ PMR)

Letter of Undertaking for Using Own Scribe

I _____, a candidate with _____ (name of the disability) appearing for the _____ (name of the examination) bearing Roll No _____ at _____ (name of the centre) in the District _____, _____ (name of the State/ UT) My qualification is _____

I do hereby state that _____ (name of the scribe) will provide the service of scribe/ reader/ lab assistant for the undersigned for taking the aforesaid examination

I do hereby undertake that his/ her qualification is _____. In case, subsequently it is found that his/ her qualification is not as declared by the undersigned and is beyond my qualification, I shall forfeit my right to the post and claims relating thereto

(Signature of the candidate with Disability)

Place:

Date: