Form-II

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 of Shri. _____

_____Date of Birth____/____/_____ Age _____years, male/female_____

(DD / MM/ YEAR)

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
- Blindness

(Please tick as applicable)

(B) The diagnosis in his/her case is ……..

(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

FORM-III

Disability Certificate
(In case of multiple disabilities)
(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 of Shri. _____

_____Date of Birth____/____/____ Age _____years, male/female_____

(DD / MM/ YEAR)

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 (to be specified) for the disabilities ticked below, and 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	Low vision	#		
3	Blindness	**Both Eyes**		
4	Hearing impairment	**£**		
5	Mental retardation	**X**		
6	Mental- illness	**X**		

(B) In the light of the above, his/her over all permanent physical impairment as per 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/both eyes
£ 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 disability certificate is issued

FORM-IV

Disability Certificate
(In cases other than those mentioned in Forms II and III)
(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 of Shri _____ _____Date of Birth____/____/_____ Age _____years, male/female_____ (DD / MM/ YEAR)

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:-

Sr.No	**Disability**	**Affected Part of Body**	**Diagnosis**	**Permanent physical impairment/mental disability (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 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/both eyes
£ 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

(Authorized Signatory of notified Medical Authority)
(Name and Seal)

Countersigned

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

{Countersignature and seal of the CMO/Medical Superintendent/ Head of Government Hospital, in case the certificate is issued by a medical authority who is not a government servant (with seal)}

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 vide notification number S.O. 908(E), Dated 31st December, 1996.

DISABILITY CERTIFICATE

As per ANNEXURE – I to OFFICE MEMORANDUM No. 336035/3/2004-Estt(Res) dated 29th December, 2005 from the Government of India, Ministry of Personnel, Public Grievances & Pensions, Department of Personnel & Training – up to 28.11.2013 as from 29.11.2013 forms of Disability Certificates have been revised as above i.e. Form II, Form III & Form IV]

NAME AND ADDRESS OF THE INSTITUTE / HOSPITAL ----------

Certificate No. ---------- Date - ----------

Recent Photograph Of the candidate showing the disability duly attested by the Chairperson of the Medical Board

This is certified that Shri / Smt./ Kum. _____ Son / wife / daughter of Shri _____age _____Sex _____identification mark(s) _____is suffering from permanent disability of following category: -

A. Locomotor or cerebral palsy:

(i) BL - Both legs affected but not arms.

(ii) BA - Both arms affected
- (a) Impaired reach
- (b) Weakness of grip

(iii) BLA - Both legs and both arms affected

(iv) OL - One leg affected (right or left)
- (a) Impaired reach
- (b) Weakness of grip
- (c) Ataxic

(v) OA - One arm affected
- (a) Impaired reach
- (b) Weakness of grip
- (c) Ataxic

(vi) BH - Stiff back and hips (Cannot sit or stoop)

(vii) MW - Muscular weakness and limited physical endurance.

B. Blindness or Low Vision:

(i) B – Blind (ii) PB - Partially Blind

C. Hearing impairment:

(i) D - Deaf

(ii) PD - Partially Deaf

(Delete the category, whichever is not applicable)

2. This condition is progressive / non-progressive / likely to improve / not likely to improve. Re -assessment of this case is not recommended / is recommended after a period of _____years _____ months*.

3. Percentage of disability in his / her case is _____per cent.

4. Sh. / Smt. / Kum. _____ meets the following physical requirement for discharge of his / her duties: -

(i)	F- can perform work by manipulating with fingers.	Yes / No
(ii)	PP - can perform work by pulling and pushing.	Yes/ No
(ii)	L - can perform work by lifting.	Yes / No
(iv)	KC - can perform work by kneeling and crouching.	Yes / No
(v)	B - can perform work by bending.	Yes / No
(vi)	S - can perform work by sitting.	Yes / No
(vii)	ST - can perform work by standing.	Yes / No
(viii)	W - can perform work by walking.	Yes / No
(ix)	SE - can perform work by seeing.	Yes / No
(x)	H - can perform work by hearing / speaking.	Yes / No
(xi)	RW - can perform work by reading and writing.	Yes / No

(Dr. _____)	(Dr. _____)	(Dr. _____)
Member Medical Board	Member Medical Board	Chairperson Medical Board

Countersigned by the
Medical Superintendent / CMO /
Head of Hospital (with seal)

**Strike out which is not applicable.*

PLEASE NOTE THAT THE FORM OF DISABILITY CERTIFICATES TO BE PRODUCED HAS BEEN REVISED VIDE O.M. NO.36035/1/2012-Estt. (Res) DATED 29th NOVEMBER, 2013. ACCORDINGLY, THE CERTIFICATES ISSUED AFTER THAT SHOULD BE IN THE REVISED FORMS AS APPLICABLE i.e. FORM II, FORM III & FORM IV AS GIVEN ABOVE.