

# ANNEXURE -1

Form - I

## Disability Certificate

(In cases of amputation or complete permanent paralysis of limbs and in cases of blindness)

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

(See rule 4)

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 (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:

1. he / she is a case of:
  - a. locomotor disability
  - b. blindness(Please tick as applicable)
2. the diagnosis in his / her case is \_\_\_\_\_
3. 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).
4. 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  
disability certificate is issued

# ANNEXURE -2

## (In cases of multiple disabilities)

### (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/Ms. \_\_\_\_\_, 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 & Language disability			
12	Intellectual disability			
13	Specific learning disability			
14	Autism Spectrum Disorder			
15	Mental Illness			
16	Chronic Neurological Conditions			

<b>Sr. No.</b>	<b>Disability</b>	<b>Affected Part of Body</b>	<b>Diagnosis</b>	<b>Permanent Physical Impairment / Mental Disability (in %)</b>
17	Multiple Sclerosis			
18	Parkinson's disease			
19	Haemophilia			
20	Thalassemia			
21	Sickle Cell disease			

@ e.g. Left / Right / Both Arms / Legs

# e.g. Single Eye

\* e.g. Left / Right / Both Ears

(B) In the light of the above, his/her overall permanent physical impairment as per guidelines (\_\_\_\_\_ number and date of issue of the guidelines to be specified), is as follows:

(C) In figures : \_\_\_\_\_ percent

(D) 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).

4. The applicant has submitted the following document as proof of residence:

<b>Name of Document</b>	<b>Date of Issue</b>	<b>Details of Authority issuing Certificate</b>

5. Signature and Seal of the Medical Authority

<b>Name &amp; Seal of Member</b>	<b>Name &amp; Seal of Member</b>	<b>Name &amp; Seal of the Chairperson</b>

Signature / thumb impression of the person in whose favour certificate of disability is issued
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# ANNEXURE - 3

Form - III

## Disability Certificate

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

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

(See rule 4)

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 (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 he / she is a case of disability.

1. His / her extent of percentage of 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	Low vision	#		
3	Blindness	Both eyes		
4	Hearing impairment	£		
5	Mental retardation			
6	Mental-illness			

@ - e.g. Left / Right / both arms / legs

# - e.g. Single eye / both eyes

£ - e.g. Left / Right / both ears

(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:
  - a. not necessary
  - b. is recommended / after \_\_\_\_\_ years \_\_\_\_\_ months, and therefore this certificate shall be valid till (DD / MM / YY) \_\_\_\_\_
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 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)}

Signature / Thumb impression of the person in whose favour disability certificate 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 vide notification number S.O. 908(E), dated the 31st December, 1996.

# ANNEXURE - 4

: cfa UhcZA YXJW 7YfhZWHY#F Ydcfhlc 6Y DfcXi WX Vmi8mgYI JW7UbXJXUH

{To be obtained from any Dyslexia Association\*}

Date: \_\_\_\_\_

## PSYCHO-EDUCATION EVALUATION REPORT

Name of the candidate:

Date of Birth:

Registration in the Dyslexia Assn. (date / number):

Name of the Father / Mother / Guardian:

Name / address and Regn. No. of the Dyslexia Association:

Physical & Neurologic Assessment: [       ]

Psychological Assessment: [       ]

WISC        Verbal IQ:  
                  Performance IQ:  
                  Full Scale IQ:

Interpretation: [       ]

Educational Assessment: [       ]

Certified that:

1. The percentage of the handicap is not less than 40%.
2. The disability is SEVERE and PERMANENT in nature and **DETAILED REPORTS OF DYSLEXIA ASSESSMENT ARE ATTACHED WITH THIS FORM (IN ORIGINAL)\*\*** .

\*\*Learning Disability is a permanent developmental disorder. Currently there are no standard approved methods to quantify the disorder. However, the method of diagnosis is based on significant impairment in academic achievement. To avail the benefit of relaxed norm under PwD category, the candidate must come under SEVERE category.

Name of the certifying official:

Seal:

