#### **DISABILITY CERTIFICATE FORMAT - II**

{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)

No		_	Da	te	_/		
Sig	nature/LTI/RTI of the Candidate					Passport	size
						photogr of the	
						candida	ate
This	s is to certify that I have carefully exan	nined Shri/Smt./	Kum				,
son	/wife/daughter of Shri		D	ate of Birth	n/_	/	
[Ag	eyears], male/female, Re	egistration No			per	manent resi	ident of
Ηοι	use No, War	d/Village/Street	:			Post	Office
		a,g.,					
pho	otograph is affixed above, and am sat						_
1.	he/she is a case of (Please tick as app	plicable):					
	a. locomotor disability						
	b. blindness						
2.	The diagnosis in his/hercase is						
3.	He / She has% (in	figure)			pe	rcent (in	words)
	permanent physical impairment/blir	ndness in relatio	n to his/her _				
	(part of body) as per guidelines (to b	e specified).					
4.	The applicant has submitted the foll	owing documen	t as proof of re	esidence:-			
	Nature of Document	Date of Issue	Detai	ls of autho	rity issuing	the certific	ate
Off	icial Seal:	•-					• • •
		[A	uthorized Signa	itory of not	titied Medi	cal Authorit	yj Name:
		_					

#### **CCMN - 2021**

## DISABILITY CERTIFICATE FORMAT - III

{In cases of multiple disabilities}

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

No	<u> </u>			Date	/	
Sig	nature/LT	TI/RTI of the Candidate				Passport size photograph of the candidate
Thi	s is to cert	ify that I have carefully e	examined Shri/Si	mt./Kum		,
son	/wife/dau	ughter of Shri		Date o	of Birth/_	
[Ag	e	years], male/female	e, Registration N	lo	per	manent resident of
Ho	use No	\ \	Ward/Village/St	reet		Post Office
		District_		State		, whose
pho	otograph i	s affixed above, and am	satisfied that			
1.	been eva	s a Case of <b>Multiple Disa</b> aluated as per guideline ant disability in the tabl	s (to be specifie			
	S. No.	Disability	Affected Part of Body	Diagnosis		nent physical t/mental disability (in %)
	1	Locomotor disability	@			
	2	Low vision	#			
	3	Blindness	Both Eyes			
	4	Hearing impairment	£			
	5	Mental retardation	Х			
	6	Mental-illness	х			

õ.	Nature of Document  Signature and seal of the Medical and Seal of Member	Date of Issue	Details o	of authority issuing the certificate  Name and Seal of the Chairperson		
	Nature of Document	Date of Issue				
	Nature of Document	Date of Issue				
5.						
5.	The applicant has submitted the fo	llowing document a	s proof of resi	idence:		
5.	The applicant has submitted the following document as proof of residence:					
	@ - e.g. Left/Right/both arms/ # - e.g. single eye/both eyes £ - e.g. Left/Right/both ears	'legs				
	valid till (DD/MM/YY)					
	(ii) Is recommended/after	years	months, a	and therefore this certificate shall be		
	(i) Not Necessary[or]					
4.	Reassessment of disability is:					
3.	The above condition is progressive	/ non-progressive/ li	kely to impro	ve/ not likely to improve.		
	In words:		per	cent		
	In figures:	%				
	specified), is as follows:					

#### **DISABILITY CERTIFICATE FORMAT-IV**

{In cases of any other case not covered in Format – II & III}

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

No				Date	/	
Sig	nature/LT	TI/RTI of the Candidate				Passport size photograph of the candidate
This	s is to cert	ify that I have carefully e	examined Shri/S	mt./Kum		
son	/wife/da	ughter of Shri		Date o	f Birth/_	
[Ag	e	years], male/female	e, Registration N	lo	pei	rmanent resident of
Ηοι	use No		Ward/Village/St	reet		Post Office
		District_		State		, whose
	He/she is	is affixed above, and ames a Case of <b>Multiple Disa</b> aluated as per guideline want disability in the tabl	<b>ability.</b> His/her of			
	S. No.	Disability	Affected Part of Body	Diagnosis		anent physical nt/mental disability (in %)
	1	Locomotor disability	@			
	2	Low vision	#			
	3	Blindness	Both Eyes			
	4	Hearing impairment	£			
	5	Mental retardation	Х			
	6	Mental-illness	х			

۷.	specified), is as follows:					
	In figures:	%				
	In words:		percent			
3.	The above condition is progressive/	non-progressive,	/ likely to improve/ not likely to improve.			
4.	Reassessment of disability is:					
	(i) Not Necessary[or]					
	(ii) Is recommended/aftervalid till (DD/MM/YY)		months, and therefore this certificate shall be			
	<ul><li>@ - e.g. Left/Right/both arms/left</li><li># - e.g. single eye/both eyes</li><li>£ - e.g. Left/Right/both ears</li></ul>	egs				
5.	The applicant has submitted the following document as proof of residence:					
	Nature of Document	Date of Issue	Details of authority issuing the certificate			
Offi	cial Seal:	[Aut	horized Signatory of notified Medical Authority*]			
		N	lame:			
cour	·	er of the District	who is not a government servant, it shall be valid only if . Note: The principal rules were published in the Gazette 1st December, 1996.			
			Countersigned			
Off	icial Seal:	[CMO	/Medical Superintendent/Head of Govt. Hospital]			
		_	lame:			

<sup>^</sup> Countersignature and seal of the CMO/Medical Superintendent/Head of Government Hospital is essential in case the certificate is issued by a medical authority who is not a government servant.