CCMN – 2023

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. -_____ **Date -**_____/_____/_____

Signature/LTI/RTI of the Candidate

Passport size photograph of the candidate

This is to certify that I have carefully examined Shri/Smt./Kum._____,

son/wife/daughter of Shri_____Date of Birth_____/_____/ _____

[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 (Please tick as applicable):
   a. locomotor disability
   b. blindness
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 the certificate

Official Seal:

[Authorized Signatory of notified Medical Authority] Name:

_____

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DISABILITY CERTIFICATE FORMAT - III

{In cases of multiple disabilities}

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

No. -_____ **Date -**_____/_____/_____

Signature/LTI/RTI of the Candidate

Passport size photograph of the candidate

This is to certify that I have carefully examined Shri/Smt./Kum._____,

son/wife/daughter of Shri_____Date of Birth_____/_____/ _____

[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 **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:

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	X		
6	Mental-illness	X		

Contd.

2. In the light of the above, his/her overall permanent physical impairment as per guidelines (to be 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/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

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

Nature of Document	Date of Issue	Details of authority issuing the certificate

6. Signature and seal of the Medical Authority:

Name and Seal of Member	**Name of Seal of Member**	**Name and Seal of the Chairperson**

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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 -**_____/_____/_____

Signature/LTI/RTI of the Candidate

Passport size photograph of the candidate

This is to certify that I have carefully examined Shri/Smt./Kum._____,

son/wife/daughter of Shri_____Date of Birth_____/_____/ _____

[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 **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:

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	X		
6	Mental-illness	X		

Contd.

2. In the light of the above, his/her overall permanent physical impairment as per guidelines (to be 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/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

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

Nature of Document	Date of Issue	Details of authority issuing the certificate

Official Seal:

[Authorized Signatory of notified Medical Authority*]

Name: _____

* 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.

Countersigned

Official Seal:

[CMO/Medical Superintendent/Head of Govt. Hospital]

Name: _____

^ 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.