

**FORM - II**  
**Disability Certificate**  
(In case of multiple disabilities)  
(Prescribed proforma subject to amendment from time to time)  
(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 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 are 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 documents 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 Chairperson

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