

**FORM-VI**

Certificate of Disability  
(In case of multiple disabilities)  
[See Rule 18(1)]

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

Certificate No.: ..... Date: .....

1. This is to certify that we have carefully examined Shri/Smt./Kum

.....son/wife/daughter

Of Shri.....Date of Birth.....(DD/MM/YYYY)

Age.....years, Male/Female.....Registration No.

.....Permanent Resident of House No. .... Ward/Village/Street

.....whose photograph is affixed above and are satisfied that:

Recent Passport  
Size  
Attested  
Photograph  
(Showing face  
only) of the person  
with disability

(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:

S. No.	Disability	Affected Part of Body	Diagnosis	Permanent Physical Impairment/ Mental Disability (in%)
1	Locomotors 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 and Language disability			
12	Intellectual Disability			
13	Specific Learning Disability			
14	Autism Spectrum Disorder			
15	Mental illness			
16	Chronic Neurological Conditions			
17	Multiple Sclerosis			
18	Parkinson's Disease			
19	Hemophilia			
20	Thalassemia			
21	Sickle Cell disease			

(B) In the light of the above, his/her overall 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 .....Year .....months, and therefore this certificate shall be valid till  
.....(DD/MM/YYYY)

@ 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