

**FORM-VII****(As per RPD Act, 2016)****Certificate of Disability****(In cases other than those mentioned in Forms-V & VI)****{See Rule 18(1)}****(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 I 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 he/she is a case of  
\_\_\_\_\_ 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) 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			
17	Multiple Sclerosis			
18	Parkinson's disease			
19	Haemophilia			

<b>Sr. No.</b>	<b>Disability</b>	<b>Affected Part of Body</b>	<b>Diagnosis</b>	<b>Permanent Physical Impairment / Mental Disability (in %)</b>
20	Thalassemia			
21	Sickle Cell disease			

*(Please strike out the disabilities which are not applicable)*

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

# e.g. Single Eye

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

2. The above 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>

(Authorised Signatory of Notified Medical Authority  
(Name & Seal)

Countersigned  
{Countersignature & Seal of the Chief Medical Officer /  
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 certificate of disability 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.