FORM-VI

(As per RPD Act, 2016)

Certificate of Disability

(In cases of multiple disabilities)
{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 we 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:

(A) he/she is a case of Multiple 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) for the disabilities ticked below, 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			

Sr. No.	Disability	Affected Part of Body	Diagnosis	Permanent Physical Impairment / Mental Disability (in %)
17	Multiple Sclerosis			
18	Parkinson's disease			
19	Haemophilia			
20	Thalassemia			
21	Sickle Cell disease			

@ e.g. Left / Right / Both Arms / Legs
# e.g. Single Eye
* e.g. Left / Right / Both Ears

(B) In the light of the above, his/her overall permanent physical impairment as per guidelines (_____ number and date of issue of the guidelines to be specified), is as follows:
(C) In figures : _____ percent
(D) 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).

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

Name of Document	Date of Issue	Details of Authority issuing Certificate

5. Signature and Seal of the Medical Authority

Name & Seal of Member	Name & Seal of Member	Name & Seal of the Chairperson

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