

Form-V

Certificate of Disability

(In cases of amputation or complete permanent paralysis of limbs or dwarfism and in case of blindness)

[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./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 am satisfied that:

(A) he/she is a case of:

- locomotor disability
• dwarfism
• blindness

(Please tick as applicable)

(B) the diagnosis in his/her case is _____

(A) he/she has _____ % (in figure) _____ percent (in words) permanent locomotor disability/dwarfism/blindness in relation to his/her _____ (part of body) as per guidelines (.....number and date of issue of the guidelines to be specified).

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

Nature of Document	Date of Issue	Details of authority issuing certificate

(Signature and Seal of Authorised Signatory of notified Medical Authority)

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

Form - VI

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./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 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:

S. 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 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.	Haemophilia			
20.	Thalassemia			
21.	Sickle Cell disease			

(B) In the light of the above, his/her over all permanent physical impairment as per guidelines (.....number and date of issue of the 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

£ 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 certificate of disability is issued.

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			

Sr. No.	Disability	Affected Part of Body	Diagnosis	Permanent Physical Impairment / Mental Disability (in %)
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:

Name of Document	Date of Issue	Details of Authority issuing Certificate

(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

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.

NO OBJECTION CERTIFICATE

(To be produced on the Letter Head of the Department and to be filled by the Head of the Department in which the candidate is working)

1. It is certified that Mr./Mrs./Miss/Dr. _____
(designation) _____ is working in the temporary/permanent
capacity with effect from _____. **This organization has no objection in
his/her applying to the post of _____ at _____.**

2. It is certified that his/her Pay Level is _____. He/She is
drawing a Basic Pay of Rs. _____. His/Her next increment is due on
_____.

Place:

Date:

Signature _____

Name _____

Designation _____

Seal of the office _____

**(Format of certificate to be submitted by Central Government Employees
seeking age relaxation)**

**(To be produced on the Letter Head of the Department and to be filled by the
Head of the Department in which the candidate is working)**

It is certified that Shri/Smt/Kum. _____ is a
Central Government employee holding the post of
_____ in the Pay Scale/Pay Level of Rs.
_____ with 03 years regular/continuous service in the
grade as _____ w.e.f. _____.

2. There is no objection to his appearing for the post of _____ and
document verification for the said recruitment.

Signature _____

Name _____

Designation _____

Tel No _____

Office Seal _____