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 registration Nopermaner	years, male/female
No Ward/Village/Street District State	Post Office
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) permanent locomotor disability/dwarfism/blindness in (part of body) as per guidelines (number	relation to his/her
the guidelines to be specified).	

The applicant has submitted the following document as proof of

2.

residence:-

Nature Document	of	Date of Issue	Details of authority issuing certificate
			8

(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)]

Recent

size

passport attested

(Name and Address of the Medical Authority issuing the Certificate)

					photograph
					(Showing face only) of the person with disability.
Ce	rtificat	e No.			Date:
				son/w	camined Shri/Smt./Kum. ife/daughter of Shri Birth (DD/MM/YY)
		Age years	, male/fema	ale	·
sa (A) ph (tisfied he he have have he had have he	Ward/Village/S State that: /she is a case of impairment/disab number and date es ticked below, ar	Multiple Di bility has e of issue of is shown	Post O photograph sability. His/i been evalua f the guideline	ent resident of House No. ffice District is affixed above, and am ther extent of permanent ited as per guidelines es to be specified) for the relevant disability in the Permanent physical
			part of body		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						
1.2	Disability						
13	S. Specific Learning Disability						
1.4	. Autism Spectrum						
17	Disorder						
15	. Mental illness	+					
	. Chronic	+					
	Neurological						
	Conditions						
17	. Multiple sclerosis						
18	. Parkinson's						
	disease						
19	. Haemophilia						
20	. Thalassemia						
21	. Sickle Cell disease						
impairm guidelin In figure In words	the light of the lent as per guideles to be specified), is	lines (s as follows percent	number :	and d	ate of	issue of t	the cent
impro		, -	rogressive/i	ikely t	o mipro	ve/Hot like	:1y
3. Reass	essment of disabilit	y 1s:					
(i)	not necessary, or						
(ii)	is recommended/ therefore this certif						an
				(DD)	(MM)	(YY)	
(a)	e.g. Left/right/	both arms/	legs				
#	e.g. Single eye	,	-				
11	c.s. Diligic cyc						

${\mathfrak L}$	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	Name	and	Seal	of	Name and Seal of the
Membe	r			Membe	er			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

Certif	ficate N	lo.:						Date:	
This	is	to	certify	that	I	have	carefully son/wife/o	examined laughter	Shri/Smt/Ms of Shr Age egistration No of House
				. D	ate	of Birth	(DD/MM/Y	Y)	Age
			vears,	male/fen	nale			, R	egistration No
			,	,		perr	nanent	resident	of House
No.			,			•		War	d/Village/Stree
			/			Pos	st Office		d/Village/Stree Distric
					Sta	ate			, whose
photog	graph	is	affixed	above above	and	am sa His/Her <i>e</i>	ntisfied that	he/she	, whose is a case of cal impairment ,
disabi	lity has	been	evaluated	d as per s	nide	elines (ontone or perm	number :	and date of issue
of the	guidelin	es to	be specifi	ied) and i	ssho	own again	st the relevan	namger (t disability ir	and date of issue the table below
or the				ica) ana i					
Sr. No.	Disal	bilit	y		I	ffected Part of	Diagnosis	Impairn	nent Physical nent / Mental
	-		11 1 111.			Body		Disab	ility (in %)
1			<u>r disabilit</u>	•	@				
2	_		Dystrophy	<u>y</u>					
3	Lepro		ırea						
4	Dwar		· · 1						
<u>5</u>	Cereb								
	Low V		k Victim		#				
<u>7</u> 8					#				
9	Deaf	11055			*				
10		of H	earing		*				
11			Language						
11	disabi		Language						
12			al disabilit	tv					
13			arning dis						
14			ectrum D						
15	Menta								
16	Chror	nic N	eurologic	al					
	Condi								
17			clerosis						
18			's disease						
19	Haem	ophi	ilia —						

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

- 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.

^{*} e.g. Left / Right / Both Ears

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	s/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
 ,	
Di	
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	servic	e in the
grade as _		W.6	e.f		·	
	no objection to hi	_	-			and
Signature						
			Name _			
			Designa	ation		
	Tel No					
			Office S	Seal		