

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/StreetPost Office.....

DistrictStateWhose photograph

is affixed above and are satisfied that:

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

(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 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 | Hemophilia | | | |
| 20 | Thalassemia | | | |
| 21 | Sickle Cell disease | | | |

(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:

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/afteryearmonths, 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