ANNEXURE V (B)

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/Street .....Post Office.....

District .....State .....Whose 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/after .....year .....months, 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