

**Annexure-VIII (FORM-II)**

**DISABILITY CERTIFICATE  
(IN CASE OF AMPUTATION OR COMPLETE PERMANENT PARALYSIS OF LIMBS AND IN CASES OF BLINDNESS)**

(See rule 4)

**(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)**

<p><b>Recent PP size Attested Photograph (showing face only) of the person with disability</b></p>
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**Certificate No.**

**Date:**

**This is to certify that I have carefully examined**

**Shri/Smt/Kum \_\_\_\_\_ Son/wife/daughter \_\_\_\_\_**

**Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ years, male/Female \_\_\_\_\_**

Registration No. \_\_\_\_\_ permanent resident of Home 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
- blindness

(Please tick as applicable)

(B) the diagnosis in his/her case \_\_\_\_\_

(A) He/She has \_\_\_\_\_ % (in figure) \_\_\_\_\_ percent (in words) permanent physical impairment/blindness in relation to his/her \_\_\_\_\_ (part of body) as per 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 Authored Signatory of notified Medical Authority)

Signature/Thumb  impression of the person in whose favour disability certificate is issued.
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**Annexure-VIII (FORM-IV)****DISABILITY CERTIFICATE**  
(In case other than those mentioned in Forms II)(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)  
(See rule 4)Recent PP 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 he/She is a Case of \_\_\_\_\_ disability. His/her extent of percentage physical impairment/disability has been evaluated as per guidelines (to be specified) for the disabilities (to be specified) and is shown against the relevant disability in the table below:-

S.No	Disability	Affected part of the body	Diagnosis	Permanent physical impairment/mental disabilities (in %)
1.	Locomotor disability	@		
2	Low vision	#		
3.	Blindness	<b>Both Eyes</b>		
4.	Hearing impairment	\$		
5.	Mental retardation	X		
6.	Mental-illness	X		

(Please strike out the disabilities which are not applicable)

2. The above condition is progress/non progress/likely to improve/not likely to improve.

3. Reassessment of disability is:

(i) not necessary

Or

(ii) is recommended/after \_\_\_\_\_ years \_\_\_\_\_ on this, and therefore this certificate shall

be valid till \_\_\_\_\_  
(DD) (MM) (YY)

@ 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

(Authorised Signatory of notified Medical Authority

(Name and Seal)  
Countersigned

{ (Countersignature and seal of the  
CMO/Medical Superintendent /Head  
of Government Hospital, in case the  
certificates issued by a medical authority who  
is not a permanent servant (with seal)}

Signature/Thumb  
impression of the  
person in whose  
favour disability  
certificate 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 on the District.”