Pro forma – F

(For Persons with Disability Candidates)

Name and address of the Institute / Hospital:

Certificate No: Date:

Recent Photograph of the candidate showing the disability duly attested by the chairperson of the Medical Board

DISABILITY CERTIFICATE

This is to Certify that Shri/Smt/Ku……..

Son/daughter/wife of Shri……

Age ……. Sex ……. Identification mark(s)……

1. Is suffering from permanent disability of following category
   - A. Locomotors or cerebral palsy
     - (i) BL-both legs affected but not arms
     - (ii) BA-Both arms affected (a) Impaired reach (b) Weakness of grip
     - (iii) BLA-Both legs and both arms affected
     - (iv) OL-One leg affected (right or left) (a) impaired reach (b) Weakness of grip (c) Ataxic
     - (v) OA-One arm affected (a) impaired reach (b) Weakness of grip (c) Ataxic
     - (vi) BH-Stiff back and hips (Cannot sit or stoop)
     - (vii) MW-Muscular weakness and limited physical endurance
   - B. Blindness or low vision
     - (i) B-Blind
     - (ii) PB-Partially Blind
   - C. Hearing impairment
     - (i) D-Deaf
     - (ii) PD-Partially Deaf

   (Delete the category, whichever is not applicable)
2. This condition is progressive/non-progressive/likely to improve/not likely to improve. Reassessment of this case of not recommended/is recommended after a period of ……years ..... Months*.
3. Percentage of disability in his/her case is .....percent.
4. Shri./Smt/Ku… .....Meets the following physical requirements for discharge of his/her duties.

(i)	F-can perform work by manipulating with fingers	Yes/No
(ii)	PP-can perform work by pulling and pushing	Yes/No
(iii)	L-can perform work by lifting	Yes/No
(iv)	KC-can perform work by lifting	Yes/No
(v)	B-can perform work by bending	Yes/No
(vi)	S-can perform work by sitting	Yes/No
(vii)	ST-can perform work by standing	Yes/No
(viii)	W-can perform work by walking	Yes/No
(ix)	SE-can perform work by seeing	Yes/No
(x)	H-can perform work by hearing/speaking	Yes/No
(xi)	RW-can perform work by reading and writing	Yes/No

(Dr. Member Medical Board

(Dr. Member Medical Board

(Dr.) Member/Chairperson Medical Board

*Strike out which is not applicable

Countersigned by the Medical Superintendent/CMO/ Head of Hospital (with seal)

Pro forma – F1

*To be issued on the **Letter Head** of the concerned office*

(For Persons with Disability Candidates)

For Learning Disability Candidates

CERTIFICATE

Recent Photograph of the candidate

Name:……

Age :……..

Date of Birth:…….

Date of Registration : …….. L.D. No:……..

Father's Name : ……

Std : ..... School Name :

……..

Physical & Neurologic Assessment (Date :)

……

Psychologic Assessment (Date :)

……

WISC (R) Verbal IQ

Performance IQ

Global IQ

Interpretation:

Educational Assessment (Date:) WRAT : R

S

A

Certified that:

1. The percentage of Challenged is not less than 40% and is equal to.....%.
2. The disability is permanent in nature.
3. The candidate is capable of carrying out all activities related to theory and practical works as applicable to degree course in Engineering/Technology without any special concessions and exemptions.
4. This Certificate is issued as per the provisions given in the Person with Disability Act, 1995 and its amendments.
5. This certificate is issued for the purpose of his/her admission to Diploma course in Engineering/Technology for the year 20…./….

Recommendations:

(Name and Signature
of Issuing Authority)

Outward No.& Date**:**

Seal of the Office

Pro forma – F2

*To be issued on the **Letter Head** of the concerned office*

(For Persons with Disability Candidates)

Recent Passport Size Photograph of the candidate duly attested by the issuing Authority

CERTIFICATE OF DISABILITY

Certificate No..... Dated.....

Name of the Designated Disability Center

.....

This is to Certify that Mr./Mrs/Ms..... .....
aged ..... years Son/Daughter of Mr.....
R/o.....
..... ,
has the following Disability (Name of the Specified Disablity).....
and has Permanent Physical Impairment (PPI) with the Disability Range (in percentage) of .....(in words) ..... (in Figures).

Please tick on the "Specified Disability"

(Assessment may be done on the basis of Gazzete of India, Extraordinary, Part II, Section 3 Sub-section (ii), Ministry of Social Justice and Empowerment)

S/No	Disability Type	Type of Disability	Specified Disability
1	Physical Disability	A. Locomotor Disability	a. Leprosy cured person b. Cerebral palsy c. Dwarfism d. Muscular dystrophy e. Acid attack victims f. Others such as amputation, Poliomyelitics
		B. Visual Impairment	a. Blindness b. Low vision
		C. Hearing Impairment	a. Deaf b. Hard of hearing
		D. Speech & Language Disability	a. Organic/ Neurological causes
2	Intellectual disability		a. Specific learning disabilities (Perceptual Disabilities, Dyslexia, Dyscalculia, Dyspraxia & Developmental Aphasia b. Autism spectrum disorder
3	Mental Behaviour		a. Mental illness
4	Disability caused due to	a. Chronic Neurological Conditions	i. Multiple sclerosis ii. Parkinsonism
		b. Blood Disorders	i. Haemophilia ii. Thalassemia iii. Sickle cell disease

5	Multiple Disabilities including Deaf Blindness		More than one of the above specified disabilities

Conclusion: He/She is Eligibile/Not Eligibile for admission in Engineering/Pharmacy/HMCT Courses subject to his being otherwise medically fit.

Sign and Name	Sign and Name	Sign and Name
(Concerned Specialist)	(Concerned Specialist)	(Concerned Specialist)

Pro forma – F3

*To be issued on the **Letter Head** of the concerned office*

(For Persons with Disability Candidates)

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

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

Certificate No. Date:

Recent Passport Size Attested Photograph (Showing Face Only) of the person with disability.

This is to certify that I 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 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 ……

1. 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

Pro forma – F4

*To be issued on the **Letter Head** of the concerned office*

(For Persons with Disability Candidates)

(In cases of multiple disabilities)

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

Certificate No. Date:

Recent Passport Size Attested Photograph (Showing Face Only) of the person with disability.

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 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) the diagnosis in his/her case is ……

1. 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) (yyyy)

   @ 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