

**Disability Certificate**  
(In cases of multiple disabilities)  
**(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE  
CERTIFICATE)**

Certificate No. \_\_\_\_\_ Date: \_\_\_\_\_

This is to certify that I have carefully examined  
Shri/Smt. \_\_\_\_\_ son/wife/daughter  
of Shri/Smt. \_\_\_\_\_ 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 are satisfied that:

1. He/she is a Case of **Multiple Disability**. His/her extent of permanent physical impairment/disability has been evaluated as per 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	Low vision	#		
3	Blindness	Both Eyes		
4	Hearing impairment	£		
5	Mental retardation	X		
6	Mental-illness	X		



@- e.g. Left/ Right/ Both arms/ legs

# - e.g. Single eye/ Both eyes

£ - e.g. Left/ Right/ Both eyes

contd.

2. In the light of the above, his/her overall permanent physical impairment as per guidelines (to be specified), is as follows:

a. In figures: \_\_\_\_\_ percent

b. In words: \_\_\_\_\_ percent

3. The above condition is progressive/non-progressive/likely to improve/not likely to improve.

4. Reassessment of disability is:

a. Not necessary

b. Is recommended/after \_\_\_\_\_ years \_\_\_\_\_ months, and, therefore, this certificate shall be valid till (DD/MM/YY)

5. 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 the Medical Authority:

Name and Seal of  
Member

Name of Seal of  
Member

Name and Seal of  
Chairperson

6. In words: \_\_\_\_\_ percent

7. The above condition is progressive/non-progressive/likely to improve/not likely to improve.

8. Reassessment of disability is:

a. Not necessary

b. Is recommended/after \_\_\_\_\_ years \_\_\_\_\_ months, and, therefore, this certificate shall be valid till (DD/MM/YY)

9. 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 the Medical Authority:

Name and Seal of  
Member

Name of Seal of  
Member

Name and Seal of  
Chairperson