

Pro forma – F
(For Persons with Disability Candidates)

Name and address of the Institute / Hospital:

Certificate No:

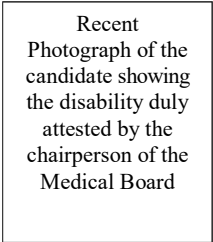
Date:

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 ofyears Months*.

3. Percentage of disability in his/her case ispercent.

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

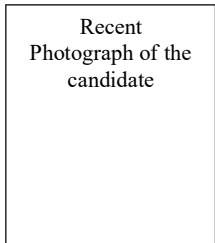
(Dr. Member Medical Board (Dr. Member Medical Board (Dr. Member/Chairperson Medical Board

*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



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:

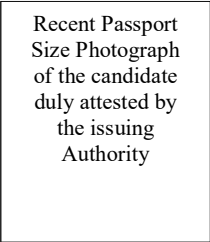
Seal of the Office

Pro forma – F2

*To be issued on the Letter Head of the concerned office
(For Persons with Disability Candidates)*

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 Disability).....
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 B. Visual Impairment C. Hearing Impairment D. Speech & Language Disability	a. Leprosy cured person b. Cerebral palsy c. Dwarfism d. Muscular dystrophy e. Acid attack victims f. Others such as amputation, Poliomyelitics a. Blindness b. Low vision a. Deaf b. Hard of hearing 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 b. Blood Disorders	i. Multiple sclerosis ii. Parkinsonism i. Haemophilia ii. Thalassemia iii. Sickle cell disease

5	Multiple Disabilities including Deaf Blindness		More than one of the above specified disabilities
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Conclusion: He/She is Eligible/Not Eligible for admission in Engineering/Pharmacy/HMCT Courses subject to his being otherwise medically fit.

Sign and Name
(Concerned Specialist)

Sign and Name
(Concerned Specialist)

Sign and Name
(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
