PROFORMA-IV

Form-V

Certificate of Disability

(In cases of amputation or complete permanent paralysis of limbs or dwarfism and in case of blindness) [See rule 18(1)]

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

Recent Passport 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:

(A) he/she is a case of:
- locomotor disability
- dwarfism
- blindness (Please tick as applicable)

(B) the diagnosis in his/her case is _____

(C) 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 Authorized Signatory of notified Medical Authority)

Signature/thumb impression of the person in whose favor certificate of disability is issued

Form - VI

Certificate of Disability
(In cases of multiple disabilities)
[See rule 18(1)]
(Name and Address of the Medical Authority issuing the Certificate)

Recent passport size attested photograph (Showing face only) of the person with disability

Certificate No Date:

This is to certify that we 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:

(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			

S No	Disability	Affected part of body	Diagnosis	Permanent physical impairment / mental disability (in %)
16.	Chronic Neurological Conditions			
17.	Multiple sclerosis			
18.	Parkinson's disease			
19.	Haemophilia			
20.	Thalassemia			
21.	Sickle Cell disease			

(B) 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/YY) _____

@ eg Left/right/both arms/legs
# eg Single eye
£ eg Left/Right/both ears 4

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

Form – VII
Certificate of Disability
(In cases other than those mentioned in Forms V and VI)
(Name and Address of the Medical Authority issuing the Certificate)
(See rule 18(1))

Recent passport 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 (……number and date of issue of the guidelines to be specified) 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.	Cerebral Palsy			
5.	Acid attack Victim			
6.	Low vision	#		
7.	Deaf	€		
8.	Hard of Hearing	€		
9.	Speech and Language disability			
10.	Intellectual Disability			
11.	Specific Learning Disability			
12.	Autism Spectrum Disorder			
13.	Mental illness			
14.	Chronic Neurological Conditions			
15.	Multiple sclerosis			

S No	Disability	Affected part of body	Diagnosis	Permanent physical impairment/mental disability (in %)
16.	Parkinson's disease			
17.	Haemophilia			
18.	Thalassemia			
19.	Sickle Cell disease			

(Please strike out the disabilities which are not applicable)

2 The above 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/YY) _____

@ - eg Left/Right/both arms/legs
# - eg Single eye/both eyes
€ - eg 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
{Counter signature and seal of the Chief Medical Officer / Medical Superintendent / Head of Government Hospital, in case the Certificate is issued by a medical authority who is not a Government servant (with seal)}

Signature/thumb impression of the person in
whose favour certificate of disability 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 of the District

PROFORMA-VII

Letter of Undertaking for Using Own Scribe

I _____, a candidate with _____ (name of the disability) appearing for the _____ (name of the examination) bearing Roll No. _____ at _____ (name of the Centre) in the District _____, _____ (name of the State/UT). My qualification is _____.

I do hereby state that _____(name of the scribe) will provide the service of scribe/reader/lab assistant for the undersigned for taking the aforesaid examination.

I do hereby undertake that his/her qualification is _____. In case, subsequently it is found that his / her qualification is not as declared by the undersigned and is beyond my qualification, I shall forfeit my right to the post and claims relating thereto.

(Signature of the candidate with Disability)

Place: _____

Date: _____

PROFORMA-VIII

Certificate regarding physical limitation in an examinee to write

This is to certify that, I have examined Mr./Ms./Mrs._____ (name of the candidate with disability), a person with _____ (nature and percentage of disability as mentioned in the certificate of disability), S/o, D/o _____ a resident of _____(Village/District/Sate) and to state that he/she has physical limitation which hampers his/her writing capabilities owning to his/her disability.

Signature
Chief Medical Officer/Civil Surgeon/Medical Superintendent
of a government health care Institution
Name & Designation

Name of Government Hospital / Health Care Centre with Seal

Place: _____
Date: _____

Note: Certificate should be given by a specialist of the relevant stream/disability (eg., Visual impairment – Ophthalmologist, Locomotor disability – Orthopedic specialist / PMR).