

Form-V
Disability Certificate

(In cases of Single Disability)

[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/UDID No.
Issue:

Date of

This is to certify that I/We have carefully examined <Name of the Applicant>, Son/Daughter/ Care of <name of father/mother/guardian>, Date of Birth (DD/MM/YY), Gender <Male/Female/Transgender>, Registration No.<UDID Enrolment No.> Resident of <address of PwD> whose photograph is affixed above, and I am/we are satisfied that:

(A) He/She is a case of (Any one of the following disabilities):

- i. Locomotor Disability
- ii. Muscular Dystrophy
- iii. Leprosy Cured
- iv. Dwarfism
- v. Cerebral Palsy
- vi. Acid Attack Victim
- vii. Low Vision
- viii. Blindness
- ix. Hearing Impairment
- x. Speech and Language Disability
- xi. Intellectual Disability
- xii. Specific Learning Disabilities
- xiii. Autism Spectrum Disorder
- xiv. Mental Illness
- xv. Chronic Neurological Conditions
- xvi. Multiple Sclerosis
- xvii. Parkinson's Disease

- xviii. Haemophilia
- xix. Thalassemia
- xx. Sickle Cell Disease

(B) Name of the affected body part:

(C) The diagnosis in his/her case is _____

(D) He/She has _____ % (in figure) _____ percent (in words) disability and the nature of certificate is {Permanent/temporary and valid till (DD/MM/YYYY)} as per the guidelines for the purpose of assessing the extent of specified disability in a person included under the Rights of Persons with Disabilities Act, 2016 notified by Government of India vide <Notification No> dated (DD/MM/YYYY).

Signature/thumb impression of the Person with Disability:

Signature of notified Medical Authority Member(s):

Signature:
Name and Address of the Medical Authority Issuing the Certificate:

Form – VI
Disability Certificate
(In cases of Multiple Disabilities)
(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./UDID No.

Date:

This is to certify that we have carefully examined

This is to certify that we have carefully examined <Name of the Applicant>, Son/Daughter/
Care of <write name of father/mother/guardian>, Date of Birth (DD/MM/YY), Gender
<Male/Female/Transgender>, Registration No.<UDID Enrolment No.> Resident of
<address of PwD> whose photograph is affixed above, and we are satisfied that:

(A) He/She is a case of **Multiple Disabilities**. His/her extent of physical
impairments/disabilities have been evaluated as per the guidelines for the purpose of
assessing the extent of specified disability in a person included under the Rights of Persons
with Disabilities Act, 2016 notified by Government of India vide <Notification No> dated
(DD/MM/YYYY) for the disabilities below:

S. No	Disability	Name of Affected body part	Diagnosis	Disability percentage
1.	Locomotor disability			
2.	Muscular Dystrophy			
3.	Leprosy cured			
4.	Dwarfism			
5.	Cerebral Palsy			
6.	Acid attack Victim			

7.	Low vision			
8.	Blindness			
9.	Hearing Impairment			
10.	Speech and Language disability			
11.	Intellectual Disability			
12.	Specific Learning Disability			
13.	Autism Spectrum Disorder			
14.	Mental illness			
15.	Chronic Neurological Conditions			
16.	Multiple sclerosis			
17.	Parkinson's disease			
18.	Haemophilia			
19.	Thalassemia			
20.	Sickle Cell disease			

(Note: Only the disabilities diagnosed will be listed)

(B) He/She has _____ % (in figure) _____ percent (in words) disability and the nature of certificate is {Permanent/temporary and valid till (DD/MM/YYYY)}

Signature/thumb impression of the Person with Disability:

Signature of notified Medical Authority Members:

Signature:
Name and Address of the Medical Authority Issuing the Certificate: