

Form-II Certificate of Disability (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) 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 _____ 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 _____ (A) 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:- <table><tr><th>Nature of Document</th><th>Date of Issue</th><th>Details of authority issuing certificate</th></tr><tr><td> </td><td> </td><td> </td></tr></table> 3. Signature and seal of the Medical Authority. (Dr.....) Member Medical Board with seal Signature/thumb impression of the person in whose favour certificate of disability is issued (Dr.....) Member Medical Board with seal (Dr.....) Chairperson Medical Board with seal Countersigned by the Chief Medical Officer (with seal)	Nature of Document	Date of Issue	Details of authority issuing certificate				(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 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) @ -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:- <table><tr><th>Nature of Document</th><th>Date of Issue</th><th>Details of authority issuing certificate</th></tr><tr><td> </td><td> </td><td> </td></tr></table> 5. Signature and seal of the Medical Authority. Signature/thumb impression of the person in whose favour certificate of disability is issued Countersigned by the Chief Medical Officer (with seal)	Nature of Document	Date of Issue	Details of authority issuing certificate																																																																																																																																																																																																									
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