

**FORM-VIII**  
(See rule 6)  
**DISABILITY CERTIFICATE**  
(In case of multiple disabilities)  
**(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING  
THE CERTIFICATE)**

Recent PP size attested photograph (Showing face only) of the person with disability
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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 are satisfied that:

(A) He/ She is a case of:

- |   |
|---|
| 1. Locomotor disability<br>2. Low vision<br>3. Visual impairment<br>4. Hearing impairment<br>5. Mental retardation<br>6. Mental illness |
|---|

(Please tick as applicable)

(B) 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:

Sl. 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		

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

In figures:- ..... per cent

In words:- ..... per cent

2. This condition is progressive/ non- progressive/likely to improve/ not likely to improve.

3. Re-assessment of disability is:

(i) not necessary,

OR

(ii) is recommended/after ..... years..... month, and therefore this certificate shall be valid till (DD/MM/YY).....

@ - e.g. left/right/both arms/legs

# - e.g. single eye/both eyes

£ - 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 which issued the 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 in whose favour disability certificate is issued.