

**Department of Empowerment of Persons with Disabilities,
Ministry of Social Justice and Empowerment, Government of India
Form-V**

Disability Certificate

(In case of Single Disability)

[See rule 18(1)]

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

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

Certificate/UDID No.

Date of Issue :

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/YYYY), 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 Diseases

xviii. Haemophilia

xix. Thalassemia

xx. Sickle Cell Disease

(B) Name of 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:

Logo of Government of India	Logo of Department of Empowerment of Persons with Disabilities, Gol	Logo of Respective State or Union Territory
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**Department of Empowerment of Persons with Disabilities,
Ministry of Social Justice and Empowerment, Government of India**

Form-VI

Disability Certificate

(In case of Multiple Disabilities)

[See rule 18(1)]

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

Recent passport size photograph (Showing face only) of the person with disability
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Certificate/UDID No.

Date of Issue:

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/YYYY) , 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/YYY) 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 Disabilities			
13	Autism Spectrum Disorder			
14	Mental Illness			
15	Chronic Neurological Conditions			
16	Multiple Sclerosis			

S. No.	Disability	Name of Affected Body Part	Diagnosis	Disability Percentage
17	Parkinson's Diseases			
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) overall 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: