Logo of Govt. of India	Logo of Department of Empowerment of Persons with Disabilities, GOI	Logo of Respective State or Union Territory

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 Govt. of India	Logo of Department of Empowerment of Persons with Disabilities, GOI	Logo of Respective State or Union Territory

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

Certificate/UDID No. Date of Issue:

This is to certify that 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 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			
11.	Intellectual Disability			
12.	Specific Learning Disabilities			
13.	Autism Spectrum Disorder			
14.	Mental Illness			
15.	Chronic Neurological			
16.	Multiple Sclerosis			
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 (D D / M M / Y Y Y Y) } .

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: