FORM-PwD (III)

Form-III
Disability Certificate
(In cases of multiple disabilities)
(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)
(See rule 4)

Recent PP 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_______________________________

whose photograph is affixed above, and are satisfied that:

1. 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:

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Disability</th>
<th>Affected Part of Body</th>
<th>Diagnosis</th>
<th>Permanent physical impairment/mental disability (in %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Locomotor disability</td>
<td>@</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Low vision</td>
<td>#</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Blindness</td>
<td>Both Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Hearing impairment</td>
<td>£</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Mental retardation</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Mental-illness</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. In the light of the above, his/her overall permanent physical impairment as per guidelines (to be specified), is as follows:
   In figures: ___________________________ percent
   In words: _______________________________ percent

3. The above condition is progressive/ non-progressive/ likely to improve/ not likely to improve.

4. 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) ______________________

5. The applicant has submitted the following document as proof of residence:

<table>
<thead>
<tr>
<th>Nature of Document</th>
<th>Date of Issue</th>
<th>Details of authority issuing certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Signature and seal of the Medical Authority:

<table>
<thead>
<tr>
<th>Name and Seal of Member</th>
<th>Name of Seal of Member</th>
<th>Name and Seal of the Chairperson</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature / Thumb impression of the person in whose favour disability certificate is issued