FORM-PwD (IV)

Form-IV
Disability Certificate
(In cases other than those mentioned in Forms II and III)
(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE
CERTIFICATE)
(See rule 4)

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 am
satisfied that he/she is a case of disability.

His/her extent of percentage of physical impairment/disability has been evaluated as per
guidelines (to be specified) and is shown against the relevant disability in the table below:

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Disability</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>
</tr>
<tr>
<td>2</td>
<td>Visual Impairment (blindness / low vision)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Hearing impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Speech and language disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Intellectual disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Mental illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Disability caused due to chronic neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>conditions and / or blood disorders</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Please strike out the disabilities which are not applicable.)
1. The above condition is progressive/ non-progressive/ likely to improve/ not likely to improve.

2. Reassessment of disability is:
   a. not necessary
   Or
   b. is recommended/after ________ years ________ months, and therefore this certificate shall be valid till (DD/MM/YY) ___________________

3. 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>

(Authorised Signatory of notified Medical Authority)
(Name and Seal)

Countersigned
{Countersignature and seal of the CMO/Medical Superintendent/Head of Government Hospital, in case the certificate is issued by a medical authority who is not a government servant (with seal)}

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

Note: In case this certificate is issued by a medical authority who is not a government servant, it shall be valid only if countersigned by the Chief Medical Officer of the District. Note: The principal rules were published in the Gazette of India vide notification number S.O. 908(E), dated the 31st December, 1996.