**FORM-VII**

**(As per RPD Act, 2016)**

**Certificate of Disability**
**(In cases other than those mentioned in Forms-V & VI)**
**{See Rule 18(1)}**
**(Name and Address of the Medical Authority issuing the Certificate)**

Recent Passport 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/Ms. _____, 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 permanent physical impairment / disability has been evaluated as per guidelines (_____ number and date of issue of the guidelines to be specified) and is shown against the relevant disability in the table below:

| Sr. No. | Disability | Affected Part of Body | Diagnosis | Permanent Physical Impairment / Mental Disability (in %) |
|---|---|---|---|---|
| 1 | Locomotor disability | @ | | |
| 2 | Muscular Dystrophy | | | |
| 3 | Leprosy cured | | | |
| 4 | Dwarfism | | | |
| 5 | Cerebral Palsy | | | |
| 6 | Acid Attack Victim | | | |
| 7 | Low Vision | # | | |
| 8 | Blindness | # | | |
| 9 | Deaf | * | | |
| 10 | Hard of Hearing | * | | |
| 11 | Speech & Language disability | | | |
| 12 | Intellectual disability | | | |
| 13 | Specific learning disability | | | |
| 14 | Autism Spectrum Disorder | | | |
| 15 | Mental Illness | | | |
| 16 | Chronic Neurological Conditions | | | |
| 17 | Multiple Sclerosis | | | |
| 18 | Parkinson's disease | | | |
| 19 | Haemophilia | | | |

| Sr. No. | Disability | Affected Part of Body | Diagnosis | Permanent Physical Impairment / Mental Disability (in %) |
|---|---|---|---|---|
| 20 | Thalassemia | | | |
| 21 | Sickle Cell disease | | | |

*(Please strike out the disabilities which are not applicable)*

@ e.g. Left / Right / Both Arms / Legs

# e.g. Single Eye

* e.g. Left / Right / Both Ears

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

3. 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).

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

| Name of Document | Date of Issue | Details of Authority issuing Certificate |
|---|---|---|
| | | |

(Authorised Signatory of Notified Medical Authority
(Name & Seal)

Countersigned
{Countersignature & Seal of the Chief Medical Officer /
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 certificate of disability 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.