

Please attach annexure XIII (13) with the relevant certificate below.
Both are necessary for claiming exemption from the typing test.

ANNEXURE-VIII

Form-V

Certificate of Disability

(In cases of amputation or complete permanent paralysis of limbs or
dwarfism and in case of blindness)

(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./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:

(A) he/she is a case of:

- locomotor disability
- dwarfism
- blindness

(Please tick as applicable)

(B) the diagnosis in his/her case is _____

(C) he/she has _____ % (in figure) _____ percent (in
words) permanent locomotor disability/dwarfism/blindness in relation to
his/her _____ (part of body) as per guidelines (.....number and
date of issue of the guidelines to be specified).

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

Nature of Document	Date of Issue	Details of authority issuing certificate

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

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

ANNEXURE-IX

Form - VI
Certificate of Disability
(In cases of multiple disabilities)

(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 we 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:

(A) he/she is a case of Multiple 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) for the disabilities ticked below, and is shown against the relevant disability in the table below:

S. 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 and 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			
20.	Thalassemia			
21.	Sickle Cell disease			

(B) In the light of the above, his/her over all permanent physical impairment as per guidelines (.....number and date of issue of the guidelines to be specified), is as follows :

In figures : - ----- percent

In words :- ----- percent

2. This 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)

@ e.g. Left/right/both arms/legs

e.g. Single eye

£ e.g. Left/Right/both ears

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

Nature of document	Date of issue	Details of authority issuing certificate

5. Signature and seal of the Medical Authority.

Name and Seal of Member	Name and Seal of Member	Name and Seal of the Chairperson

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

ANNEXURE-X

Form – VII
 Certificate of Disability
 (In cases other than those mentioned in Forms V and VI)
 (Name and Address of the Medical Authority issuing the
 Certificate)

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

S. No	Disability	Affected part of body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor disability	@		
2.	Muscular Dystrophy			
3.	Leprosy cured			
4.	Cerebral Palsy			
5.	Acid attack Victim			
6.	Low vision	#		
7.	Deaf	€		
8.	Hard of Hearing	€		
9.	Speech and Language disability			
10.	Intellectual Disability			
11.	Specific Learning Disability			
12.	Autism Spectrum Disorder			
13.	Mental illness			
14.	Chronic Neurological Conditions			
15.	Multiple sclerosis			

16.	Parkinson's disease			
17.	Haemophilia			
18.	Thalassemia			
19.	Sickle Cell disease			

(Please strike out the disabilities which are not applicable)

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) ____ ____

@ - eg. Left/Right/both arms/legs

- eg. Single eye/both eyes

€ - eg. Left/Right/both ears

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

Nature of document	Date of issue	Details of authority issuing certificate

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

Countersigned
{Countersignature and 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