FORM-V
Certificate of Disability
(In cases of amputation or complete permanent paralysis of limbs or dwarfism and in cases of blindness)

[See Rule 18(1)]
(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

Certificate No:………………………………………………………………………… Date: .........................
This is to certify that I have carefully examined
Shri/Smt/Kum………………………………………………………………………………………………..son/wife/daughter of Shri……………………………………………… …………… Date of Birth ………………………
Age………..Years, Male/Female………………
(DD/MM/YY)
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:
   *LocomotorDisability
   *Dwarfism
   *Blindness
   (Please tick as applicable)
(B) The diagnosis in his/her case is …………………………………..…………….
(1) He/She has ………….% (in figure)…………………… percent (in words) permanent locomotor
disability/dwarfism/blindness in relation to his/her ……………………..……. (part of body) as per
guidelines (to be specified).
(2) 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>
</table>

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

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