

Pro forma – F4

*To be issued on the **Letter Head** of the concerned office
(For Persons with Disability Candidates)*

(In cases of multiple disabilities)

(Name and Address of the Medical Authority issuing the Certificate)

Certificate No.

Date:

Recent Passport Size
Attested Photograph
(Showing Face Only)
of the person with
disability.

This is to certify that we have carefully examined Shri/Smt./Kum.
..... Son/wife/Daughter of Shri.....
..... Date of Birth (dd/mm/yyyy)..... 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) the diagnosis in his/her case is

1. 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 wordsPercent

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 yearsmonths, and therefore this certificate shall be valid till/...../.....

(dd) (mm) (yyyy)

@ 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