

Logo of Government of India	Logo of Department of Empowerment of Persons with Disabilities, GoI	Logo of Respective State or Union Territory
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**Department of Empowerment of Persons with Disabilities,
Ministry of Social justice and Empowerment, Government of India**

FORM-V

Disability Certificate

(In cases of Single Disability)

[See rule 18(1)]

(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)

Recent PP Size
Attested
Photograph
(Showing face only)
of the Person with
disability

Certificate/UDID No: _____

Date: _____

This is to certify that I/we have carefully examined

Shri/Smt/Kum _____ son/ wife/ daughter of Shri

_____ Date of Birth _____ (DD/MM/YYYY)

Age _____ Years, Male/Female/Transgender _____ Registration No. _____

Permanent Resident of House No. _____ Ward/Village/Street _____

Post Office _____ District _____ State _____ whose

photograph is affixed above, and I am/we satisfied that:

(A) He/she is a case of (Any one of the following disabilities:

- i. Locomotor Disability
- ii. Muscular Dystrophy
- iii. Leprosy cured
- iv. Dwarfism
- v. Cerebral Palsy
- vi. Acid Attack Victim

- vii. Low vision
- viii. Blindness
- ix. Hearing Impairment
- x. Speech and Language Disability
- xi. Intellectual Disability
- xii. Specific Learning Disabilities
- xiii. Autism Spectrum Disorder
- xiv. Mental illness
- xv. Chronic Neurological Conditions
- xvi. Multiple sclerosis
- xvii. Parkinson's disease
- xviii. Haemophilia
- xix. Thalassemia
- xx. Sickle Cell disease

(B) Name of affected body part:

(C) The diagnosis in his/her case is _____

(D) He/She has _____% (in figure)_____ percent (in words)
Disability and the nature of certificate is {Permanent / Temporary and valid till (DD/MM/YYYY)} as
per the guidelines for the purpose of assessing the extent of specified disability in a person included
under the Rights of Persons with Disabilities Act, 2016 notified by Government of India vide
_____ number dated _____.

Signature/Thumb impression of the Person with Disability:

Signature of notified Medical Authority Members:

Signature:

Name and Address of the Medical Authority Issuing the Certificate: