

PRESCRIBED PROFORMA FOR APPLICATION

ANNEXURE - I

POST APPLIED FOR : _____

1. Name:
2. Father's / Husband's Name:
3. Date of birth:
(Self-attested copy of proof to be enclosed)
4. Age (As on 01/05/2018):
5. Sex:
6. Permanent Address:
.....
7. Address for Communication:
.....
8. Telephone: Landline:
Mobile:
9. E-mail Address:
10. Nationality:
11. Religion:
12. Category (Please tick): SC / ST/ OBC / UR
(Self attested copy of proof to be enclosed)
13. Category of PWD (Please tick): OH / VH/ HH
(Self attested copy of proof to be enclosed)
14. Percentage of Disability :%
(Certificate of Disability to be enclosed as per **Annexure – II**)
15. Qualification: (Self attested copy of Proof to be enclosed)

Affix Recent Passport size Photo here
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Name of the Examination	Percentage % with Division / Class	Name of the University / Board / College	Honours / Pass course
Class - X			
Class - XII			
Graduation			
Post-Graduation / Diploma			
Additional			

16. Experience: (Self attested copy of Proof to be enclosed)

Organisation	Scale of pay & Present Basic Pay	Post	Period (_____to_____)	Duration

17. Additional Information (if any)

I certify that the above information is true to the best of my knowledge and belief. The necessary documents, including the certificate from my employer, are enclosed.

(Full Signature of Applicant with Date)

Form-II

Disability Certificate

**(In cases of amputation or complete permanent paralysis of limbs
and in cases of blindness)
(See rule 4)**

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

Recent PP 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 _____ 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:

- locomotor disability
- blindness

(Please tick as applicable)

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

(A) He/ She has%(in figure)..... percent
(in words) permanent physical impairment/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:-

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 disability
certificate is
issued.

Form-III

Disability Certificate
(In case of multiple disabilities)
(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE
CERTIFICATE)
(See rule 4)

Recent PP 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 _____ 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 are 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 (to be specified) for the disabilities ticked below, and 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	Low vision	#		
3	Blindness	Both Eyes		
4	Hearing impairment	£		
5	Mental retardation	X		
6	Mental-illness	X		

(B) In the light of the above, his /her over all permanent physical impairment as per 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/both eyes
 £ 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 disability certificate is issued.

Form-IV**Disability Certificate**
(In cases other than those mentioned in Forms II and III)**(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE
CERTIFICATE)**
(See rule 4)

Recent	PP	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 _____ 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 he/she is a case

of _____ disability. His/her extent of percentage physical

impairment/disability has been evaluated as per 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	Low vision	*		
3	Blindness	Both Eyes		
4	Hearing impairment	£		
5	Mental retardation	X		
6	Mental-illness	X		

(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)

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

* e.g. Single eye/both eyes

£ 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

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

Countersigned

{Countersignature and seal of the CMO/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 disability
certificate 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."

Note: The principal rules were published in the Gazette of India vide notification number S.O. 908(E), dated the 31st December, 1996.