Medical Superintendent Office
All India Institute of Medical Sciences, Jodhpur

Disability Application Form

Filled by Patient / Attendant: -

Name : - ______________________________ **Sex: -**___

Date of Birth : - ____/____/____ **Age: -**___

Father's/ Husband's Name : - ______________________________

Mobile No. : - ________________&________________

Hospital Id : - ______________________________

Address : - ______________________________

____

I hereby certify that the information provided above is true and correct.

Date: __/__/____ **Signature:** - Patient / Attendant

Filled by Consultant: -

Consultant Name : - ______________________________

Department : - ______________________________

Nature of Disability : - ______________________________

Other Departments that may be required for evaluation: - (1) ____________________

(2) ____________________

(3) ____________________

Verified by Consultant (with signature and seal) : - ____________________

Basni Phase II, Jodhpur- 342005 (Rajasthan), India website: www.aiimsjodhpur.edu.in

All India Institute of Medical Sciences
Jodhpur

DISABILITY CERTIFICATE

[The application and issuance of the disability certificate is in accordance to the Gazette notifications of Government of India{ EXTRAORDINARY, PART II- Section 3- Sub section (i); No. 489; New Delhi, Thursday, June 15, 2017/Jyaistha 25, 1939 (REGD. NO. D. L. -33004/99)} *AND* {EXTRAORDINARY, PART II- Section 3- Sub section (ii); No. 61; New Delhi, Friday, January 05, 2018/Pausha 15, 1939 (REGD. NO. D. L. -33004/99)}]

Certificate No. - _____ **Date: - ---------------**

Hospital: **All India Institute of Medical Sciences (AIIMS),**
Basni Phase 1, Jodhpur, Rajasthan 342005.

Recent Photograph of candidate

1. This is certified that I have carefully examined **Mr./Mrs/Miss** .... S/o/D/o/W/o ...., Date of Birth ...., Age- ..... **Years ....Months,** Permanent resident of...
....
....

Identifications mark(s):-

(i) ....
....

(ii) ....
....

Whose photograph is affixed and had applied for disability certificate on **dated: ....,**
Vide Application No. – ......

Sr. No.	Disability	Affected Part of Body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotors 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 condition			
17	Multiple sclerosis			
18	Parkinson's disease			
19	Hemophilia			
20	Thalassemia			
21	Sickle Cell disease			

(Please strike out the disabilities which are not applicable)

Basni Phase-2, Jodhpur, Rajasthan-342 005, **Phone :** 0291-2740741 Fax : 0291-2740531 **Website :** www.aiimsjodhpur.edu.in

2. The above condition is progressive/non-progressive/likely to improve/not likely to improve.

3. Reassessment of disability is:
   a. Is recommended after ……… Years and therefore this certificate shall be valid till……………………
   b. Not recommended.

4. Percentage of disability as per guideline is **……………..%.**

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

Name of the document	Number	Details of authority issuing certificate
AADHAR CARD	………………………	**UIDAI**

Dr. ……………………

Signature………………..
Chairman of Medical Board

Dr. ……………………

Signature………………..
Member of Medical Board
(Subject Expert)

Dr. ……………………

Signature………………..
Member of Medical Board
(Subject Expert)

Dr. ………………………………

Signature………………..
Member of Medical Board
(Subject Expert)

Dr. …………………

Signature………………..
Member of Medical Board
(Subject Expert)

Sign/Thumb Impression
of the person whose in favour
Certificate of disability is issued

Counter Signed by
Medical Superintendent/
CMO/HOD of Hospital
(With seal)