GOVERNMENT OF PUNJAB  
DEPARTMENT OF HEALTH & FAMILY WELFARE  
(HEALTH-5 BRANCH)  

NOTIFICATION  

Dated, Chandigarh The 15 September, 2011  

No. 21/43/2010-5HB5/2539  

In pursuance of the provisions of sub-clause (p) of Section 2 of 'The persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995' and 'The persons with disabilities (Equal Opportunities, Protection of Rights and Full Participation) Punjab Rules, 2003' and 'The persons with disabilities (Equal Opportunities Protection of Rights and Full Participation) Punjab (... Ist...., Amendment) Rules, 2011', the Govt of Punjab hereby specifies, for the purpose of issuance of certificate of disability as mentioned in sub-clause (i) of the said section 2, the hospitals and institutions mentioned in column 3 of the table given below, as "medical authorities" for the type of disability mentioned in column 2 thereof, and further directs that the medical officer of the hospital / institution as mentioned in Col 4 shall be authorized to sign the disability certificate on behalf of the medical authority.

<table>
<thead>
<tr>
<th>SN</th>
<th>Type of Disability</th>
<th>Hospital / Institution which is being specified as the &quot;Medical Authority&quot; for the purpose of the disability mentioned in Col 2</th>
<th>Medical Officer working in the Hospital / Institution mentioned in Col 3 who would be competent to issue certificate of disability</th>
</tr>
</thead>
</table>
| 1  | Obvious Disability on Form-II  
(i) Locomotor Disability by way only of amputation or complete permanent paralysis of limbs.  
(ii) Blindness | All District Hospitals, Sub-Divisional Hospitals, Community Health Centres and Primary Health Centres | Medical Superintendent / SMO or a Senior Doctor authorized by an order of MS / SMO of the hospital, SMO of CHC / SMO of PHC / MO incharge PHC |
| 2  | Multiple Disability on Form-III  
Sub-Divisional Hospitals having (a) Specialists and (b) necessary measurement / assessment / evaluation facilities in relevant fields (eg. audiometric, optometric and other testing facilities). | All District Hospitals and Sub-Divisional Hospitals  
(a) Specialists and (b) necessary measurement / assessment / evaluation facilities in relevant fields (eg. audiometric, optometric and other testing facilities). | A medical board as may be specified by a Medical Superintendent or Senior Medical Officer of the District Hospital / Sub-Divisional Hospital, headed by a Senior Specialist and consisting of doctors with post-graduate degree in the disciplines dealing with relevant disabilities. |
<table>
<thead>
<tr>
<th>3</th>
<th>Single Disability on Form-IV (Disabilities not mentioned at SN 1 &amp; 2 above)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All District Hospitals, Sub-Divisional Hospitals, Community Health Centres</td>
</tr>
<tr>
<td></td>
<td>A doctor having a PG degree in the disciplines dealing with relevant</td>
</tr>
<tr>
<td></td>
<td>disabilities with a minimum of 3 years of specialists and necessary</td>
</tr>
<tr>
<td></td>
<td>service duty authorized by the Head of the Institution i.e. MS /</td>
</tr>
<tr>
<td></td>
<td>facilities in relevant SMO fields (eg. Audiometric, optometric and other</td>
</tr>
<tr>
<td></td>
<td>testing facilities).</td>
</tr>
</tbody>
</table>

Note:

(i) For 3 types of disability certificates, hospitals as mentioned in Col 3 above have been notified as medical authority. In the event of non-availability of the concerned specialist in a particular health institution mentioned in Col 3, the SMO / MO incharge of that health institution would refer the applicant to the nearest higher health institutions where such specialists / facilities are available.

(ii) Likewise, if a hospital mentioned in Col 3 above does not have the requisite assessment facilities for various disabilities, the head of such hospital may utilize the facilities available in the hospital of the Health Department in a nearby place in the district or refer the case to the Medical Colleges for testing facilities. The Medical Colleges where such cases can be referred are:

- Govt Medical College, Amritsar
- Govt Medical College, Patiala
- Govt Medical College, Faridkot
- Christian Medical College, Ludhiana
- Dayanand Medical College, Ludhiana
- Shri Guru Ram Das Medical College, Amritsar
- Gian Sagar Medical College, Banur
- Adesh Medical College, Bathinda
- Punjab Institute of Medical Sciences, Jalandhar
- Govt Medical College, Sector-32, Chandigarh
- Post Graduate Institute of Medical Education & Research (PGIMER), Chandigarh
(iii) **Explanation**:

- Primary Health Centre means Block Primary Health Centre or Primary Health Centre run by Department of Health & Family Welfare.
- Community Health Centre means a Community Health Centre notified by the State Government as CHC and run by Punjab Health Systems Corporation.
- Sub-Divisional Hospital means a hospital notified by the State Government as SDH and run by Punjab Health Systems Corporation.
- District Hospital means Civil Hospital situated at district headquarter and run by Punjab Health Systems Corporation.

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Satish Chandra  
Principal Secretary to Govt of Punjab  
Department of Health & Family Welfare  
Dated, Chandigarh 15-9-2011  
A copy with a spare copy is forwarded to the Controller, Printing and Stationary, Punjab, Chandigarh with a request that this notification may please be published in the ordinary gazette and supply 500 copies of this notification to the Government for official use.

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Additional Secretary Health (S)  
Dated, Chandigarh 15-9-2011  
A copy is forwarded to the following for information and necessary action:-

1) All Heads of Departments, Registrar Punjab & Haryana High Court, Chandigarh, Commissioners of Divisions, District & Sessions Judges, Deputy Commissioner’s in the State, All Civil Surgeons in the State and Principals Government Medical/Dental Colleges, Amritsar, Faridkot and Patiala.
2) Secretary Home, Chandigarh Administration, U.T., Chandigarh;
3) Accountant General (A&E), Punjab, Chandigarh;
4) Accountant General (Audit), Punjab, Chandigarh;
5) Resident Commissioner, Punjab, Copernicus Marg, Punjab Bhawan, New Delhi;
6) Director, Health & Family Welfare, Punjab, Chandigarh;
7) Director, P.G.I. Chandigarh;
8) Director, Government Medical College & Hospital, Sector-32, Chandigarh;
9) Director, Social Security Women and Child Development, Punjab, Chandigarh;
10) Director, Public Relation, Punjab, Chandigarh;

Additional Secretary Health (S)
A copy is forwarded to All the Administrative Secretaries and Financial Commissioners to Government of Punjab for information and necessary action.

To
All the Administrative Secretaries and Financial Commissioners.

I.D. No. 21/43/2010-5HB3/ 2542  Dated, Chandigarh 15-9-2011
A copy is forwarded to the Principal Secretary to Govt. of Punjab, Department of Social Security, Women and Child Development w.r.t. their Notification No. 8/20/2010-SSS/452, dated 7-6-2011 for information and necessary action.

To
The Principal Secretary to Govt. of Punjab,
Department of Social Security Women and Child Development,
Punjab, Chandigarh.

I.D. No. 21/43/2010-5HB3/ 2543  Dated, Chandigarh 15-9-2011
APPLICATION FOR OBTAINING DISABILITY CERTIFICATE BY PERSONS WITH DISABILITIES
(See Rule 3)

1. Name ____________________________
   (Surname) ________________________
   (First name) _______________________
   (Middle name) _____________________

2. Father's Name ______________________
   Mother's name _______________________

3. Date of Birth: __ / __ / _____
   DD / MM / YYYY

4. Age at the time of application: ________ years

5. Sex: Male/Female

6. Address:
   (a) Permanent address _______________________
       _______________________
       _______________________
       _______________________

   (b) Current Address (i.e. for communication) _______________________
       _______________________
       _______________________
       _______________________

   (c) Period since when residing at current address _______________________

7. Education Status (Pl. tick as applicable)
   (I) Post Graduate / Graduate / Diploma
   (II) Higher Secondary / High School / Middle
   (III) Primary / Illiterate

8. Occupation ____________________________

9. Identification marks (i) _______________ (ii) _______________________

10. Nature of disability: Visual/ Hearing/ Locomotor/ Mental/others
11. Period since when disabled: From Birth/ Since year ____________________

12. (i) Did you ever apply for issue of a disability certificate in the past? ___YES/NO
   (ii) If yes, details:
      (a) Authority to whom and district in which applied ____________________________
      (b) Result of application ____________________________________________________

13. Have you ever been issued a disability certificate in the past? If yes, please enclose a true copy of
Certificate No. ___________________________ Date _____ / _____ / _______ Issued By ___________________________

Declaration: I hereby declare that all particulars stated above are true to the best of my knowledge and belief, and no material information has been concealed or misstated. I further, state that if any inaccuracy or detected in the application. I shall be liable to forfeiture of any benefits derived and other action as per law.

__________________________________________
(Signature or left thumb impression of person with disability, or of his/her legal guardian in case of persons with mental retardation, autism, cerebral palsy and multiple disabilities)

Date: _____ / _____ / _______
Place: _________________________
Encl:

1. Proof of residence (Please enclose a copy of one of the following documents)
   (a) ration card,
   (b) voter identity card,
   (c) driving license
   (d) bank passbook
   (e) PAN card,
   (f) passport,
   (g) telephone, electricity, water and any other utility bill indicating the address of
   the applicant.
   (h) a certificate of residence issued by a Panchayat, municipality, cantonment
   board, and gazetted officer, or the concerned Patwari or Head Master of a Govt. school.
   (i) in case of an inmate of a residential institution for persons with disabilities,
   destitute, mentally ill, etc., a certificate of residence from the head of such institution.

2. Two recent passport size photographs

   (For office use only)

   Date:                      . Signature of Issuing Authority
   Place:                      Stamp
Form-II
DISABILITY CERTIFICATE (OBVIOUS DISABILITY)
(In cases of amputation or complete permanent paralysis of limbs
and in cases of blindness)
(See rule 4)
(NAME AND ADDRESS OF THE HEALTH INSTITUTION)

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 / YYYY)

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 notified by Ministry of Social Justice and Empowerment No. 16-18/97-N.I.I, New Delhi dated 1st June, 2001 and amended from time to time.

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 Medical authority Issuing certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Name:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Address:</td>
</tr>
</tbody>
</table>

Signature-

Seal-

Signature/ Thumb impression of the person whose favour disability certificate is issued
Form-III

DISABILITY CERTIFICATE
(In case multiple disabilities)
(NAME AND ADDRESS OF THE HEALTH INSTITUTION)
(See rule 4)

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/YYYY)

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 notified by Ministry of
Social Justice and Empowerment No. 16-18/97-NI.I, New Delhi dated 1st June,
2001 and amended from time to time for the disabilities ticked below, and shown
again: the relevant disability in the table below: 
<table>
<thead>
<tr>
<th>S. No.</th>
<th>Disability</th>
<th>Affected part of Body</th>
<th>Diagnosis</th>
<th>Permanent physical Impairment/mental disability (In %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Locomotor disability</td>
<td>@</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Low vision</td>
<td>#</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Blindness</td>
<td>Both Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Hearing impairment</td>
<td>£</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Mental retardation</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Mental-illness</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(B) In the light of the above, his/her over all permanent physical impairment as per guidelines notified by Ministry of Social Justice and Empowerment No. 16-18/97-NI-I, New Delhi dated 1st June, 2001, 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 / YYYY)

- @ - 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:

<table>
<thead>
<tr>
<th>Nature of Document</th>
<th>Date of issue</th>
<th>Details of authority issuing certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Signature and seal of the Medical Authority.

<table>
<thead>
<tr>
<th>Name and seal of Member</th>
<th>Name and seal of Member</th>
<th>Name and seal of the Chairperson</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature/ Thumb impression of the person whose favour disability certificate is issued
Form-IV
DISABILITY CERTIFICATE (SINGLE DISABILITY)
(In case other than those mentioned in Forms II and III)
(NAME AND ADDRESS OF THE HEALTH INSTITUTION)
(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 / YYYY)

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 notified by Ministry of Social
Justice and Empowerment No. 16-18/97-NI.I, new Delhi dated 1st June, 2001 and
amended from time to time and is shown against the relevant disability in the table
below:-
<table>
<thead>
<tr>
<th>Serial No.</th>
<th>Disability</th>
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<th>Diagnosis</th>
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<td>Both Eyes</td>
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<td></td>
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<td>4</td>
<td>Hearing impairment</td>
<td>£</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Mental retardation</td>
<td>X</td>
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<tr>
<td>6</td>
<td>Mental-illness</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(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 / YYYY)

- @ - e.g. Left/Right/both arms/legs
- # - e.g. Single eye/both eyes
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4. The applicant has submitted the following document as proof of residence:

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<tr>
<td></td>
<td></td>
<td>Name:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Address:</td>
</tr>
</tbody>
</table>

Signature-

Seal-
Form-V
Intimation of Rejection of Application for Disability Certificate
(In cases other than those mentioned in Forms II and III)
(See rule 4)

No. _______________ Dated: _______________

To

(Name and address of applicant
for Disability Certificate)

Subject: Rejection of Application for Disability Certificate.

Sir/Madam,

Please refer to your application dated ________ for issue of a Disability Certificate for the following disability:

________________________________________________________________________

2. Pursuant to the above application, dated, you were examined by the undersigned/ Medical Board on ________________ and I regret to inform that, for the reasons mentioned below, it is not possible to issue a disability certificate in your favour:

   (i) 
   (ii) 
   (iii) 

3. In case, you are aggrieved by the rejection of your application, you may represent to ________________________________ requesting for review of this decision.

Yours faithfully,

Signature-
Name-
Address-
Seal-