

Appendix 5.

Disability Certificate-I (Form – II)

Disability Certificate

(In cases of amputation or complete permanent paralysis of limbs and in cases of blindness)

(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 (DD/MM/YY) _____ 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:

1. S/he is a case of:
 - a. locomotor disability
 - b. blindness(Please tick as applicable)
2. The diagnosis in his/her case is _____
3. S/he has _____% (in figure) _____ percent (in words) permanent physical impairment/blindness in relation to his/her _____ (part of body) as per guidelines (to be specified).
4. 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.

Appendix 6.

Disability Certificate-II (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 I have carefully examined Shri/Smt./Kum. _____ son/ wife/ daughter of Shri _____

Date of Birth (DD/MM/YY) _____ Age _____ years, male/female _____

Registration No. _____ permanent resident of House No. _____

Ward/Village/Street _____ Post Office _____ District _____ State _____, whose photograph is affixed above, and

are satisfied that:

1. S/he 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			
6	Mental-illness			
7	Disability caused due to chronic neurological conditions			
8	Disability caused due to blood disorder			

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

- e.g. Single eye/both eyes

£ - e.g. Left/Right/both ears

2. In the light of the above, his/her overall permanent physical impairment as per guidelines (to be specified), is as follows:

In figures: _____ percent

In words: _____ percent

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

4. Reassessment of disability is:

(i) not necessary

(ii) is recommended/after _____ years _____ months, and therefore this certificate shall be valid till (DD/MM/YY) _____

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

Nature of Document	Date of Issue	Details of authority issuing certificate

6. Signature and seal of the Medical Authority

Name and Seal of Member (1)	Name and Seal of Member (2)	Name and Seal of the Chairperson

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Signature/Thumb impression of the person in whose favour disability certificate is issued.

Appendix 7.

Disability Certificate-III (Form – IV)

Disability Certificate

(In case other than those mentioned in Disability Certificates I and II)

(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 (DD/MM/YY) _____ Age _____ years, male/female _____

Registration No. _____ permanent resident of House No.

_____ Ward/Village/Street _____ Post Office

_____ District _____ State

_____, whose photograph is affixed above, and are satisfied
that he/she is a case of disability.

1. His/her extent of percentage of 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	Diagnosis	Permanent physical impairment / mental disability (in %)
1	Locomotor disability		
2	Low vision		
3	Blindness		
4	Hearing impairment		
5	Mental retardation		
6	Mental-illness		
7	Disability caused due to chronic neurological conditions		
8	Disability caused due to blood disorder		

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

- e.g. Single eye/both eyes

£ - e.g. Left/Right/both ears

(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:
 - a. not necessary
 - b. is recommended / after _____ years _____ months, and therefore this certificate shall be valid till (DD/MM/YY) _____
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: 1. 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.

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

Appendix 8.

Format of Medical Certificate / Report to be Produced by Dyslexic Candidate – Form Dyslexic-1

{To be obtained from any Government or Government approved Learning Disability Clinic/Neurodevelopmental Centre/Dyslexia Association}

Date: _____

PSYCHO-EDUCATION EVALUATION REPORT

Name of the Candidate: _____

Date of Birth: _____

Registration in the Dyslexia Assn. (date/number): _____

Name of the Father/Mother/Guardian: _____

Name/address and Regn. No. of the Dyslexia Association: _____

Recent PP size
attested
photograph of
the candidate

Physical & Neurologic Assessment: []

Psychological Assessment: []

WISC Verbal IQ:
 Performance IQ:
 Full Scale IQ:

Interpretation: []

Educational Assessment: []

Certified that:

1. The condition of handicap is: MILD / MODERATE / SEVERE (tick whichever is applicable)*.
2. The disability is **PERMANENT** in nature and **DETAILED REPORTS OF DYSLEXIA ASSESSMENT ARE ATTACHED WITH THIS FORM (IN ORIGINAL)**.

****Learning Disability is a permanent developmental disorder. Currently there are no standard approved methods to quantify the disorder. However, the method of diagnosis is based on significant impairment in academic achievement.**

Signature and Name (in CAPITAL LETTERS) of the certifying official:

Seal:

Appendix 9.

Certificate to be Produced by Dyslexic Candidate from the Principal of the College/Institution Last Attended — Form Dyslexic 2

TESTIMONIAL

Date: _____

Name of the candidate: _____

Date of Birth: _____

Name and Address of the School / College: _____

Certified that Shri/Smt./Kum. _____

son/daughter of _____ of _____

village/town passed his/her degree/diploma or equivalent from this college/institution and as per records, availed concession under dyslexic category.

Signature with seal:

**A candidate passing degree/diploma or equivalent through private mode/distance learning/ correspondence course may submit the certificate to this effect from the competent authority of the board/university certifying the concessions availed under dyslexia.*

Recent PP size
attested
photograph of
the candidate

Appendix 10.

Format of the letter for obtaining permission to utilize scribe (Amanuensis) for PwD candidates

(as per letter issued from the Ministry of Social Justice and Empowerment, Department of Empowerment of Persons with Disabilities (Divyangjan) F. No. P-13013/75/2023-Policy-DD-III, dated 1st Aug 2025)

Certificate for recommendation of scribe/reader/lab assistant and/or Compensatory Time for persons with disabilities as defined under Section 2(s) of the RPwD Act 2016 and have limitation in writing as specified in the Guidelines.

1. This is to certify that, we have examined Mr./ Ms./ Mrs.
_____ (name of the candidate), S/o /D/o
_____ a resident of

(Village/ PO/ PS/ District/ State), aged_____yrs, a person
with_____ (nature of disability/condition),and to state that he/ she has
limitation which hampers his/ her writing capability owing to his/her above disability/condition. He/
she requires support of scribe/ reader/lab assistant/and or Compensatory Time as specified in the
Guidelines, for writing the examination.

2. The above candidate uses aids and assistive device such as prosthetics & orthotics, hearing aid (name to be specified)/ other (to be specified), which is/are essential for the candidate to appear at the examination with the assistance of scribe.

3. This certificate is issued only for the purpose of appearing in written examinations conducted by Examining Bodies and is valid up to (it is valid for maximum period of one year or less as may be certified by the medical authority)

Signature of medical authority

Name of Government Hospital/ Health Care Centre with Seal

Place

Date

Appendix 11.

Request Letter Format for Amanuensis (Scribe) and/or Compensatory Time for PwD Candidates

Date: _____

Name of the Candidate: _____

Address: _____

Mobile No: _____ Email: _____

The Chairperson,
UCEED-CEED 2027,
IIT Bombay

Subject: Requirement of COMPENSATORY TIME and/or Amanuensis (scribe)

Dear Sir,

I am a PwD candidate (Visually impaired/dyslexic/disability in the upper limbs or loss of fingers).

(tick as applicable)

- ☐ I would like to request you to provide compensatory time of 20 minutes per hour to complete the paper as per the government norms. I understand that the compensatory time of Part-A and Part-B are non-transferable.
- ☐ I would like to avail of the services of an amanuensis (scribe).

I have separately uploaded my PwD certificate.

I understand that if it is subsequently discovered at any stage that I have used the services of a scribe, and/or have availed compensatory time, but do not possess the extent of disability that warrants either of the above, I shall be excluded from the process of evaluation, ranking and admission. In case I have already been admitted to any institute, my admission will be CANCELLED.

Thanking you,

Signature of the Candidate: _____

Signature of the Parent/Guardian: _____

Name of the Parent/Guardian: _____