

1. मैं जाति से सम्बन्ध रखता/ रखती हूँ, जो उत्तर प्रदेश हेतु अधिसूचित अनुसूचित जाति, अनुसूचित जनजाति, एवं अन्य पिछड़ा वर्ग की सूची में सूचीबद्ध नहीं है।
2. मेरे परिवार की कुल श्रौतों (वैतन, कृषि, व्यवसाय, पेशा इत्यादि) से कुल वार्षिक आय रु (शब्दों में) है।
3. मेरे परिवार के पास उल्लिखित आय के सिवाय अथवा इसके अतिरिक्त अन्यत्र कोई परिसम्पत्ति नहीं है।

अथवा

- कई स्थानों पर स्थित परिसम्पत्तियों को जोड़ने के पश्चात भी मैं (नाम) आर्थिक रूप से कमजोर वर्ग के दायरे में आता/ आती हूँ।
4. मैं घोषणा करता/ करती हूँ कि मेरे परिवार की सभी परिसम्पत्तियों को जोड़ने के पश्चात् निम्नलिखित में से किसी भी सीमा से अधिक नहीं है।
 - I. 5 (पाँच) एकड़ कृषि योग्य भूमि अथवा उससे ऊपर।
 - II. एक हजार वर्ग फीट अथवा इससे, अधिक क्षेत्रफल का प्लेटे।
 - III. अधिसूचित नगरपालिका के अंतर्गत 100 वर्ग गज अथवा इससे अधिक का आवासीय भूखण्ड।
 - IV. अधिसूचित नगरपालिका से इतर 200 वर्ग गज अथवा इससे अधिक का आवासीय भूखण्ड।

मैं प्रमाणित करता/ करती हूँ कि मेरे द्वारा उपरोक्त जानकारी मेरे ज्ञान और विश्वास के अनुसार सत्य है और मैं आर्थिक रूप से कमजोर वर्ग के लिए आरक्षण सुविधा प्राप्त करने हेतु पात्रता धारण करता/ करती हूँ। यदि मेरे द्वारा दी गई जानकारी असत्य/ गलत पायी जाती है तो मैं पूर्ण रूप में जानता हूँ/ जानती हूँ कि इस आवेदन पत्र के आधार पर दिये गये प्रमाण पत्र के द्वारा शैक्षणिक संस्थान में लिया गया प्रवेश/ लोक सेवाओं एवं पदों में प्राप्त की गई नियुक्ति निरस्त कर दी जायेगी/ कर दिया जायेगा अथवा इस प्रमाण पत्र के आधार पर कोई अन्य सुविधा/ लाभ प्राप्त किया गया है उससे भी वंचित किया जा सकेगा और इस सम्बन्ध में विधि एवं नियमों के अधीन मेरे विरुद्ध की जाने वाली कार्यवाही के लिए मैं उत्तरदायी रहूँगा/ रहूँगी।

नोट:- जो लागू नहीं हो उसे काट दें।
स्थान :- आवेदक/ आवेदिका का हस्ताक्षर तथा पूरा नाम।
दिनांक:-

Form-I
Certificate of Disability
(In cases of multiple disabilities)
 (Name and Address of the Medical Authority/Board issuing the Certificate)

Recent passport 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 (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:
 (A) he/she is a case of Multiple Disability. His/her extent of permanent physical impairment/disability has been evaluated as per guidelines (.....number and date of issue of the guidelines to be specified) for the disabilities ticked below, and is shown against the relevant disability in the table below:

| S. N. | Disability | Affected part of body | Diagnosis | Permanent physical impairment/ mental disability (in%) |
|-------|---------------------------------|-----------------------|-----------|--|
| 1. | Locomotor 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 Conditions | | | |
| 17. | Multiple sclerosis | | | |
| 18. | Parkinson's disease | | | |
| 19. | Haemophilia | | | |
| 20. | Thalassemia | | | |
| 21. | Sickle Cell disease | | | |

(B) In the light of the above, his/her over all permanent physical impairment as per guidelines (.....number and date of issue of the 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
 £ - 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 certificate of disability is issued

Countersigned by the Chief Medical Officer (with seal)

Form-IV
Certificate of Disability
(In cases of other than those mentioned in Forms II and III)
 (Name and Address of the Medical Authority/Board issuing the Certificate)

Recent passport 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 (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:
 (A) he/she is a case of Multiple Disability. His/her extent of percentage physical impairment/disability has been evaluated as per guidelines (.....number and date of issue of the guidelines to be specified) for the disabilities ticked below, and is shown against the relevant disability in the table below:

| S. N. | Disability | Affected part of body | Diagnosis | Permanent physical impairment/ mental disability (in%) |
|-------|---------------------------------|-----------------------|-----------|--|
| 1. | Locomotor disability | @ | | |
| 2. | Muscular Dystrophy | | | |
| 3. | Leprosy cured | | | |
| 4. | Cerebral Palsy | | | |
| 5. | Acid attack Victim | | | |
| 6. | Low Vision | # | | |
| 7. | Deaf | £ | | |
| 8. | Hard of Hearing | £ | | |
| 9. | Speech and Language disability | | | |
| 10. | Intellectual Disability | | | |
| 11. | Specific Learning Disability | | | |
| 12. | Autism Spectrum Disorder | | | |
| 13. | Mental illness | | | |
| 14. | Chronic Neurological Conditions | | | |
| 15. | Multiple sclerosis | | | |
| 16. | Parkinson's disease | | | |
| 17. | Haemophilia | | | |
| 18. | Thalassemia | | | |
| 19. | Sickle Cell disease | | | |

(Please strike out the disabilities which is 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. 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 certificate of disability is issued

Countersigned by the Chief Medical Officer (with seal)

प्रमाणित किया जाता है कि श्री/श्रीमती/कुमारी नगर निवासी ग्राम तहसील जिला उत्तर प्रदेश लोक सेवा (शासिक) रूप से विकलांग, स्वतंत्रता संग्राम सेनानियों के आश्रित और भूतपूर्व सैनिकों के लिये आरक्षण) अधिनियम, 1993 के अनुसार स्वतंत्रता संग्राम सेनानी हैं और श्री/ श्रीमती/ कुमारी (आश्रित) पुत्र/ पुत्री/ पौत्र/ पौत्री/ पौत्र का पुत्र या पुत्री का पुत्र) तथा पौत्री (पुत्र की पुत्री या पुत्री की पुत्री) (विवाहित अथवा अविवाहित) उपरोक्त अधिनियम, 1993 (स्थापना) के प्रावधानों के अनुसार उक्त श्री/ श्रीमती (स्वतंत्रता संग्राम सेनानी) के आश्रित हैं।
 स्थान: हस्ताक्षर
 दिनांक: पूरा नाम

Form-II
Certificate of Disability
 (In cases of amputation or complete permanent paralysis of limbs or dwarfism and in case of blindness)
 (Name and Address of the Medical Authority issuing the Certificate)

Recent passport 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:
 (A) he/she is a case of:
 ● locomotor disability
 ● dwarfism
 ● blindness
 (Please tick as applicable)
 (B) The diagnosis in his/her case is _____ percent
 (A) he/she has _____ % (in figure) _____ percent (in words) permanent locomotor disability/ dwarfism/blindness in relation to his/her _____ (in words) permanent locomotor disability/ dwarfism/blindness in relation to his/her _____ (part of body) as per guidelines (.....number and date of issue of the 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 |
|--------------------|---------------|--|
| | | |

3. Signature and seal of the Medical Authority.
 (Dr.....) (Dr.....) (Dr.....)
 Member Medical Board with seal Member Medical Board with seal Chairperson Medical Board with seal

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

Chief Medical Officer (with seal)

