







पोस्ट ऑफिस \_\_\_\_\_ थाना \_\_\_\_\_ ब्लाक \_\_\_\_\_  
 तहसील \_\_\_\_\_ जिला \_\_\_\_\_ राज्य \_\_\_\_\_  
 ने आर्थिक रूप से कमजोर वर्ग के प्रमाण पत्र हेतु आवेदन दिया है,  
 पत्रद्वारा घोषणा करता/करती हूँ-  
 1. मैं \_\_\_\_\_ जाति से सम्बन्ध रखता/रखती हूँ, जो उत्तर प्रदेश हेतु अधिवृत्त अनुसूचित जाति, अनुसूचित जनजाति एवं अन्य पिछड़ा वर्ग की सूची में सूचीबद्ध नहीं है।  
 2. मेरे परिवार को कुल स्रोतों (वेतन, कृषि, व्यवसाय, पेशा इत्यादि) से कुल वार्षिक आय रु \_\_\_\_\_ (शब्दों में) है।  
 3. मेरे परिवार के पास उल्लिखित आय के रिसाय अथवा इसके अतिरिक्त अन्य 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 पश्चात 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 प्लॉट।  
 III. अधिवृत्त नगरपालिका के अंतर्गत 100 वर्ग गज अथवा इससे अधिक का आवासीय भूखण्ड।  
 IV. अधिवृत्त 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 पत्रांतर धारण करता/करती हूँ। यदि मेरे द्वारा दी गई जानकारी अशुद्ध/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 :- आवेदन/आवेदिका का हस्ताक्षर तथा पुरा नाम।**  
**दिनांक-** \_\_\_\_\_

**उपरोक्त के दिव्यांग व्यक्तियों के लिये प्रमाण-पत्र (दिव्यांगजन प्रारूप)**

**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/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 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 \_\_\_\_\_  
 (C) 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 Member Chairperson  
 Medical Board Medical Board Medical Board  
 with seal with seal with seal

Counter signed by the person in whose favour certificate of disability is issued  
 \_\_\_\_\_  
 Chief Medical Officer (with seal)

**Form-III**  
**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  
 \_\_\_\_\_  
 Chief Medical Officer (with seal)

**Form-IV**  
**Certificate of Disability**  
**(In cases of other than those mentioned in Forms I 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 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 satisfied that he/she is a case of 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) 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 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. 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)

उत्तर प्रदेश लोक सेवा (हायब्रिट) रूप से विकलांग, स्वतंत्रता संग्राम सेनानियों के आश्रितों और मरुपूरव सैनिकों के लिये आरक्षण अधिनियम, 1993 (व्यवसायोपेत) के अनुसार स्वतंत्रता संग्राम सेनानी के आश्रित के लिये प्रमाण-पत्र

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

