

**GOVERNMENT OF WEST BENGAL**  
**Department of Women & Child Development and Social Welfare**  
**Writers' Buildings, Kolkata- 700 001**

**NOTIFICATION**

**No. 9835-SW/1A-14/97Part-I.-27<sup>th</sup> December, 2011.-** In exercise of the power conferred by sub-sections (1) and (2) of section 73 of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1 of 1996), the Governor is pleased hereby to make the following amendments in the West Bengal Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Rules, 1999 (hereinafter referred to as the said rules):-

*Amendments*

In the said rules, -

(1) In Chapter I, under the sub-heading "Preliminary", for rule 2, *substitute* the following rules:-

**"2. Definition.** – (1) In these rules unless the context otherwise requires, -

- (a) "Act" means the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (1 of 1996);
- (b) "certificate" or "disability certificate" means a certificate issued in pursuance of clause (t) of section 2 of the Act;
- (c) "Form" means a Form appended to these rules;
- (d) "multiple disabilities" means a combination of two or more disabilities as defined in clause (i) of section 2 of the Act;
- (e) "year" means the Financial Year commencing on the 1<sup>st</sup> day of April.

(2) Words and expressions used, but not defined in these rules, shall have the same meanings respectively assigned to them in the Act.";

(2) in Chapter II, -

(a) for the sub-heading "**Guidelines for evaluation and assessment of various disabilities**", *substitute* the following sub-heading:-

**"Disability Certificate and Identity Card.";**

(b) for rules 3, 4, 5 and 6, *substitute* the following rules:-

**"3. Medical authority.** - (1) Every Primary Health Centre, Block Primary Health Centre, State General Hospital, Rural Hospital, Sub-Divisional Hospital or the District Hospital run by the State Government or any hospital run by a Statutory body or authority, shall be the medical authority for the purposes of the Act.

(2) Every Officer-in-Charge or Medical Head of the Institution, by whatever name it is called, of the concerned medical authority mentioned in sub-rule (1) shall be authorized to sign the disability certificate on behalf of that medical authority.

**4. Application for issue of disability certificate.** -- (1) A person with disability desirous of getting a certificate in his favour shall submit an application in Form V, along with the-

(a) proof of residence, and

(b) two recent passport size photographs.

(2) The application under sub-rule (1) shall be submitted to –

(a) a medical authority competent to issue such a certificate in the district of the applicant's residence as mentioned in the proof of residence submitted by him with the application, or

(b) the concerned medical authority, where he may be undergoing or may have undergone treatment in connection with his disability:

Provided that where a person with disability is a minor or suffering from mental retardation or any other disability which renders him unfit or unable to make such an application himself, the application on his behalf may be made by his parents or legal guardian.

**5. Issue of disability certificate.** – (1) On receipt of an application under rule 4, the medical authority shall, after satisfying himself that the applicant is a person with disability as defined in sub-clause (t) of section 2 of the Act, issue a disability certificate in his favour in Form VI, Form VII or Form VIII, as the case may be.

(2) The certificate shall be issued by the medical authority as soon as practicable, normally within a week but in any case, within thirty days from the date of receipt of the application.

(3) The medical authority shall, after due examination –

(a) give a permanent disability certificate in cases, where there are no chances of variation, over time, in the degree of disability, and

(b) shall indicate the period of validity in the certificate, in cases where there is any chance of variation, over time, in the degree of disability.

4) If an applicant is found ineligible for issue of disability certificate, the medical authority shall explain to him the reasons for rejection of his application, and shall also intimate the reasons to him in writing in Form IX.

(5) A certificate issued under this rule shall render a person eligible to apply for facilities, concessions and benefits admissible under schemes of the Government and of Non-Governmental Organizations funded by the Government, subject such conditions as may be specified in relevant schemes or instructions of Government, as the case may be.

**6. Review of a decision regarding issue of, or refusal to issue, a disability certificate.** – (1) Any person aggrieved by the nature of a certificate issued to him, or by refusal to issue such a certificate in his favour, as the case may be, may represent his

case against such a decision to the Appellate Medical Board constituted under sub-rule (1) of rule 7:

Provided that where a person with disability is a minor or suffering from mental retardation or any other disability which renders him unfit or unable to make such an application himself, the application on his behalf may be made by his parents or legal guardian.

(2) The application for review shall be accompanied by a copy of the certificate or letter of rejection being appealed against.

(3) On receipt of an application for review, the Appellate Medical Board shall, after giving the appellant an opportunity of being heard, pass such orders on it as it may deemed fit and appropriate.

(4) Every application for review shall be disposed by the Appellate Medical Board as soon as practicable, normally within fifteen days but in any case, within thirty days from the date of receipt of the application.

**6A. Identity Card.** – (1) Each person with disabilities shall be entitled to receive an ‘Identity Card’ to be issued by appropriate authority.

(2) (a) In Kolkata, such appropriate authority shall be the competent authority declared under the Act or the Director, Social Welfare/Commissioner for Persons with Disabilities or his equivalent or any officer authorized by the competent authority authorized by him, as the case may be.

(b) In the Districts, such appropriate authority shall be the District Social Welfare Officer or the District Programme Officer/Child Development Project Officer”.

(c) in rule 7, *omit* sub-rule (7);

(3) after Form IV, *insert* the following Forms:-

**“Form-V**

**APPLICATION FOR OBTAINING DISABILITY CERTIFICATE BY  
PERSONS WITH DISABILITIES**

*(See rule 4)*

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1. Name .....  
(Surname) (First Name) (Middle Name)

2. i) Father’s Name ..... ii) 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 (for communication)

.....  
.....  
.....  
PIN ..... PIN.....

(c) Period since when residing at current address .....

7. Educational Status (Please tick as applicable)

- (i) Post Graduate
- (ii) Graduate
- (iii) Diploma
- (iv) Higher Secondary
- (v) High School
- (vi) Middle
- (vii) Primary
- (viii) Illiterate

8. Occupation .....

9. Identification Marks (i) ..... (ii) .....

10. Nature of Disability: locomotor/ hearing/ visual/ 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, please detail:-

(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.

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 is 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 his/her legal guardian in case of persons with mental retardation, autism, cerebral palsy and multiple disabilities.)

Date: .....

Place: .....

Enclosure:

1. Proof of residence (Please tick as applicable)

- (a) Ration Card
- (b) Voter Identity Card
- (c) Driving License
- (d) Bank Passbook
- (e) PAN Card
- (f) Passport
- (g) Telephone, Electricity, Water or any other utility bill indicating the address of the applicant.
- (h) A Certificate of Residence issued by a Panchayat, Municipality, Cantonment Board or any other Gazetted Officer or the concerned Patwari or Head Master of a Govt. School.
- (i) In case of an inmate of a residential institution for person with disabilities, destitute, mentally ill etc. a certificate of residence from the head of such institution.

2. Two recent passport sized photographs.

.....  
(for office use only)

Date:

Signature of Issuing Authority

Place:

Stamp

**Form-VI**

**DISABILITY CERTIFICATE**

**(In cases of amputation or complete permanent paralysis of limbs and in cases of blindness)**  
(See rule 5)

**(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE CERTIFICATE)**

Affix 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./Km.

\_\_\_\_\_

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 \_\_\_\_\_ PIN 

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Whose photography 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 .....

(C) He/She has .....% (in figure) .....percent (in words) permanent physical impairment/blindness in relation to his/her ..... (part of body) as per guidelines (to be specified).

2. The applicant has submitted the following document as proof of resident:-

Nature of Document	Date of Issue	Details of authority issuing certificate

(Signature and Seal of Authorized Signatory of Notified Medical Authority)

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

**Form-VII**  
**DISABILITY CERTIFICATE**  
**(In cases of multiple disabilities)**  
**(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE**  
**CERTIFICATE)**  
*(See rule 5)*

Affix 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./Km. \_\_\_\_\_  
 \_\_\_\_\_ 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 \_\_\_\_\_ PIN

whose photograph is affixed above, and am satisfied that:

(A) He/She is a case of **Multiple Disabilities**. 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:-

Sl. 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	1		
5.	Mental retardation	X		
6.	Mental-illness	X		

(B) In the light of the above, his/her over all permanent physical impairment as per 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) (YYYY)

@ e.g. Left/Right/Both Arms/Legs

# e.g. Single Eye/Both Eyes

l e.g. Left/Right/Both Ears

4. The applicant has submitted the following documents as proof of residence:-

Nature of Document	Date of Issue	Details of Authority issuing certificate

5. Signature and Seal of the Medical Authority:-

Name & Seal of Member	Name & Seal of Member	Name & Seal of Chairperson

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

**Form-VIII**  
**DISABILITY CERTIFICATE**  
(In cases of other than those mentioned in Forms VI & VII)  
(NAME AND ADDRESS OF THE MEDICAL AUTHORITY ISSUING THE  
CERTIFICATE)  
(See rule 5)

Affix 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./Km. \_\_\_\_\_  
\_\_\_\_\_ 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 \_\_\_\_\_ PIN

whose photograph is affixed above, and am satisfied that he/she is a case of  
.....Disability. His/her extent of percentage for  
physical impairment/disability has been evaluated as per guidelines (to be specified)  
is shown against the relevant disability in the table below:-

Sl. 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	1		
5.	Mental Retardation	X		
6.	Mental Illness	X		

(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

1 e.g. Left/Right/Both Ears

4. The applicant has submitted the following documents as proof of residence:-

Nature of Document	Date of Issue	Details of Authority issuing certificate

(Authorized Signature and Seal of the Medical Authority)  
(Name & Seal)

----- Signature/Thumb Impression of the person in whose favour disability certificate is issued.
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Countersigned

[Countersigned and Seal of the  
CMO/Medical Superintendent/  
Head of Govt. Hospital, in case  
Of the certificate is issued by a  
Medical Authority who is not a  
Govt. Servant (with Seal)]

**Note 1: In case, this certificate is issued by a Medical Authority, who is not a Govt. Servant, it shall be valid only if, it shall be countersigned by the Chief Medical Officer of the District.**

**Note 2: The Principal Rules were published in the Calcutta Gazette vide Notification Number 2101-SW/1A- 14/97, dated the 8<sup>th</sup> July, 1999.**

**Form-IX**

**Intimation of Rejection of Application for Disability Certificate**  
(See rule 5)

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No. ....

Dated: /...../.....

To

(Name & Address of Applicant  
for Disability Certificate)

**Sub: Rejection of Application for Disability Certificate.**

Sir/Madam,

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

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2. Pursuant to the above application, you have been 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,

(Authorized Signature and Seal of the Medical Authority)  
(Name & Seal)"

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By order of the Governor,

**DR. (MS) T. KUMAR,**

*Principal Secretary to the Government of West Bengal.*