Proof of Disability Certificate

Personal Information:

Name: [Full Name]

Date of Birth: [DD/MM/YYYY]

Address: [Street, City, State, ZIP Code]

Contact Number: [Phone Number]

Disability Details:

Type of Disability: [Specify Disability]

Severity: [Mild / Moderate / Severe]

Duration: [Temporary / Permanent]

Assistive Devices (if any): [Specify if applicable]

Medical Certification:

This is to certify that the individual named above has been diagnosed with [Specify Disability] and meets the criteria for disability recognition under applicable regulations.
The condition has been assessed by a qualified medical professional and verified to affect their daily activities
and functional abilities.

Medical Practitioner Details:

Name: [Doctor's Name]

Medical License Number: [License Number]

Institution: [Hospital/Clinic Name]

Contact: [Phone / Email]

Signature & Stamp:

Signature: _____

Date: [DD/MM/YYYY]

Official Stamp (if applicable):

Disclaimer: This certificate is issued solely for official and legal purposes and should not be altered or misused. Verification may be required by relevant authorities.