Staff Selection Commission (MPR), Raipur

Important Notice

Attention: Candidates of CGL-2019 examination seeking exemption from appearing in the skill Test (DEST)

OH candidates qualified in Tier-III of CGL Examination,2019 and seeking exemption from appearing in Skill Test (DEST) for the post of Tax Assistant in CBDT, are required to bring following documents at the time of document verification.

(a) Medical Certificate for exemption from appearing in Skill Test (DEST) from Civil Surgeon as per **Annexure-II.**

(b) PWD Certificate from notified Medical Authority as per **Annexure-XI (Form-V) or Annexure-XIII (Form-VII)** whichever is applicable as per notice of the Examination.

OH candidates opting for the post of Tax Assistant in CBDT are exempted from appearing in Skill Test, provided such candidates submit a Certificate in the prescribed format (**Annexure-XIV**) to the Commission from the competent Medical Authority, i.e., the Civil Surgeon of a Government Health Care Institution declaring him/ her to be permanently unfit for the Typing Test because of a physical disability. OH candidates opting for post of Tax Assistant in CBEC are not exempted from Skill Test. HH and VH candidates are not eligible for exemption from the Skill Test.

No exemption from CPT is allowed for any category of PWD candidates.

The candidates are required to produce all these documents in original before the Commission at the time of document verification. If any candidate fails to produce the same during document verification, such candidates will have no claim against the Commission's decision.

Assistant Director (Exam)

ANNEXURE - XIV

FORM OF MEDICAL CERTIFICATE TO BE PRODUCED BY OH CANDIDATES WITH BENCHMARK DISABILITY WHO SEEK EXEMPTION FROM APPEARING IN THE SKILL TEST (DEST) FOR CGLE, ~~2020~~ 2019

This is to certify that Sh./Smt./Kum _____son/daughter/wife of Shri _____is suffering from _____.

Clinical diagnosis as a result of which he/ she has the following disabilities. (Brief description of his/ her disabilities) ----------
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This is a permanent disability and the extent of his/ her disability works out to ____% of disability.

This disability is likely to interfere with Typewriting (specify)

Signature of Civil Surgeon:

Name:

(Official Stamp)

Place:

Date:

Photograph of candidate clearly showing face with affected portion of the body

Signature of candidate:

Name:

Annexure-XI

Form-V

Certificate of Disability

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

[See rule 18(1)]

(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 _____

(C) he/she has _____ % (in figure) _____ percent (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

(Signature and Seal of Authorised Signatory of notified Medical Authority)

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

Annexure-XII

Form - VI
Certificate of Disability
(In cases of multiple disabilities)
[See rule 18(1)]
(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 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. No	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.

Annexure-XIII

Form – VII
Certificate of Disability
(In cases other than those mentioned in Forms V and VI)
(Name and Address of the Medical Authority issuing the Certificate)
(See rule 18(1))

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 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. No	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) ____ ____ ____

@ - eg. Left/Right/both arms/legs

- eg. Single eye/both eyes

€ - eg. 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

(Authorized Signatory of notified Medical Authority)

(Name and Seal)

Countersigned
{Countersignature and seal of the
Chief Medical Officer/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 certificate of disability is issued

Note: 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