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)
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, 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) ___________________________________________________________

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:
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)

Certificate No.

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:-

<table>
<thead>
<tr>
<th>Nature of Document</th>
<th>Date of Issue</th>
<th>Details of authority issuing certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Signature/thumb impression of the person
in whose favour certificate of disability is issued
Form - VI
Certificate of Disability
(In cases of multiple disabilities)
[See rule 18(1)]
(Name and Address of the Medical Authority issuing the Certificate)

Certificate No.                      Date:

This is to certify that we have carefully examined Shri/Smt./Kum.

                                      son/wife/daughter of Shri

                                      Age ____ years, male/female ________________

                                      Date of Birth (DD/MM/YY) ________________

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:

<table>
<thead>
<tr>
<th>S. No</th>
<th>Disability</th>
<th>Affected part of body</th>
<th>Diagnosis</th>
<th>Permanent physical impairment/mental disability (in %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Locomotor disability</td>
<td>@</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Muscular Dystrophy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Leprosy cured</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Dwarfism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Cerebral Palsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Acid attack Victim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Low vision</td>
<td>#</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Blindness</td>
<td>#</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Deaf</td>
<td>£</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Hard of Hearing</td>
<td>£</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Speech and Language disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Intellectual Disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Specific Learning Disability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Mental illness</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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:

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5. Signature and seal of the Medical Authority.

<table>
<thead>
<tr>
<th>Name and Seal of Member</th>
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<th>Name and Seal of the Chairperson</th>
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Signature/thumb impression of the person in whose favour certificate of disability is issued.
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:

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<td>Autism Spectrum Disorder</td>
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16. Parkinson's disease
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(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

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(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