

Staff Selection Commission
Karnataka – Kerala Region
Bangalore
No.04/07/2018-SSC (KKR) Vol.IV
Important Notice

Attention: OH Candidates with Benchmark disability of CGLE-2018 Skill Test seeking exemption from appearing in DEST

- Note:**
- I. Exemption is allowed for the Post of Tax Assistant in CBDT only.
 - II. Exemption is NOT allowed for CPT for any candidate.

'OH' Candidates with Benchmark disability having limitation in typing, who claim to be permanently unfit to take the DEST because of Physical limitation in typing and seek exemption from appearing in DEST are required to send self attested **scanned copies** of following documents on email ID: adexam.kkr.ssc@gov.in, latest **by 16-12-2020 by 2.00 PM.**

- (i) Medical Certificate as per the attached format (i.e., Annexure-I) issued by 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 only).
 - All the columns must be duly filled in and signed by **Civil Surgeon** of a Health Care Institution only as per the format.
 - The issuing authority **must specify in writing** against the column "This disability is likely to interfere with Typewriting"
- (ii) Certificate of Disability in proof of his/her claim for belonging to OH category with benchmark disability in the prescribed format as per **Annexure-VIII** (Form-II or IV as applicable) of the exam notice (Copy enclosed).
- (iii) Undertaking as per the attached Annexure-II to this notice.

Alternatively, the candidates may also report at the venue for skill test on the day of the Test to the Venue Head **well before** the reporting time, along with aforementioned documents (original & photocopy) for seeking exemption from appearing in DEST.

The Venue Head will forward the copy of Certificate by e-mail to SSC (KKR). The decision of Commission on grant of exemption will be conveyed to the candidate immediately, vide e-mail, through the Venue Head.

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, Commission would cancel the candidature of such candidate for this exam and such candidates will have no claim against the Commission's decision.

Annexure-I

FORM OF MEDICAL CERTIFICATE TO BE PRODUCED BY OH CANDIDATES WITH
BENCHMARK DISABILITY WHO SEEK EXEMPTION FROM APPEARING IN THE
DATA ENTRY SPEED TEST (DEST) FOR CGLE, 2018.

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:

Roll Number:

UNDERTAKING

I _____, Roll No. _____ am a candidate of CGLE 2018 Examination and would like to avail exemption from the requirement of appearing and qualifying in DEST for the post of Tax Assistant in CBDT only, in accordance with Note-I of Para 9.6.1 of examination notice, as I am permanently unfit to take the typing test because of physical disability. I am herewith attaching a copy of requisite certificate in prescribed format, issued by competent medical authority i.e. a civil surgeon of a Government health care institution along with relevant medical certificate in prescribed format as per annexure VIII of the notice of examination.

I also undertake that I will produce all these documents in original during document verification before the Commission. If I fail to produce the same, the Commission may cancel my candidature for this examination and I will have no claim against the Commission's decision.

DISABILITY CERTIFICATE
(IN CASE OF AMPUTATION OR COMPLETE PERMANENT PARALYSIS OF
LIMBS AND IN CASES OF BLINDNESS)

(See rule 4)

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

Recent PP 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 _____ Age
 _____ years, male/Female _____

(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:

- locomotor disability
- blindness

(Please tick as applicable)

(B) The diagnosis in his/her case _____

(A) 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 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
disability certificate is issued.

DISABILITY CERTIFICATE

(In case other than those mentioned in Forms II and III)

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

(See rule 4)

Recent PP 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 (to be specified) for the disabilities (to be
specified) and is shown against the relevant disability in the table below:-

S.No.	Disability	Affected part of the body	Diagnosis	Permanent physical impairment/mental disabilities (in %)
1.	Locomotor disability	@		
2.	Low vision	#		
3.	Blindness	Both Eyes		
4.	Hearing impairment	\$		
5.	Mental retardation	X		
6.	Mental-illness	X		

(Please strike out the disabilities which are not applicable)

2. The above condition is progress/non progress/likely to improve/not likely to improve.

3. Reassessment of disability is:

(i) not necessary

Or

(ii) is recommended after _____ years _____ on this, 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. The applicant has submitted the following document as proof of residence:

Nature of Document	Date of issue	Details of authority issuing certificate

(Authorised Signatory of notified Medical Authority
(Name and Seal)
Countersigned

{ (Countersignature and seal of the
CMO/Medical Superintendent /Head
of Government Hospital, in case the
certificates issued by a medical authority who is not a
permanent servant (with seal)}

Signature/Thumb impression of
the person in whose favour
disability certificate 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 on the District."