

Staff Selection Commission (Eastern Region)

IMPORTANT NOTICE

Attention: Candidates of CGL 2021 Examination seeking exemption from appearing in the Skill Test (DEST).

OH candidates qualified in Tier-III of CGL Examination 2021 and seeking exemption from appearing in Skill Test (DEST) for the post of Tax Assistant in CBDT are required to send undertaking as per Annexure along with following documents on email ID: contact-ssc@gov.in latest by 30.12.2022.

- (a) Medical Certificate for exemption from appearing in Skill Test (DEST) from Civil Surgeon as per Annexure - XVI of the notice of examination.
- (b) PWD Certificate from notified Medical Authority as per Annexure- XIII (Form V) to Annexure XV (Form VII), whichever is applicable, as per the 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-XVI) to the Commission from the competent Medical Authority, i.e., the Civil Surgeon of a Government Health Care Institution declaring him to be permanently unfit for the Typing Test because of a physical disability. OH candidates opting for post of Tax Assistant in CBEC and UDC/ SSA in Central Bureau of Narcotics are not exempted from Skill Test. All other PwD candidates are not eligible for exemption from the Skill Test. No exemption from CPT is allowed for any category of PwD candidates.

Alternatively, the candidates may also report at the venue of Skill Test (DEST) on the date of their Skill test (DEST) along with aforementioned documents (original & photocopy) for seeking exemption from appearing in Skill Test (DEST).

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


(Arun Kumar Sarkar)

Deputy Secretary
Staff Selection Commission
(Eastern Region)

Dated: 26.12.2022

UNDERTAKING

I _____, Roll No. _____ am an OH candidate of Combined Graduate Level Examination, 2021 and would like to avail exemption from appearing in the Skill Test (DEST) in accordance with Para 13.12.1.4 of the Notice of the Examination as I am permanently unfit to take the typing test because of physical disability. I am attaching a copy of each of the following documents:

- (i) Medical Certificate for exemption from appearing in Skill Test (DEST) from Civil Surgeon as per Annexure XVI of the notice of the examination.
- (ii) PwD Certificate from notified Medical Authority as per Annexure XIII (Form V) to Annexure XV (Form VII), whichever is applicable, as per the notice of the 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.

SIGNATURE.....

NAME OF CANDIDATE.....

ROLL NO.....

DATE.....

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

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.

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

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.

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: