Staff Selection Commission (WR)
Mumbai

F.No.E.E.11012/11/2023/CHSL-2023/Exam/SSC(WR)

Skill Test for Combined Higher Secondary Level Examination,2024

Important Notice

Subject: Orthopedically Handicapped candidates of CHSL-2024 examination seeking exemption from appearing in Typing Test - reg

As per Para No. 13.9.7.7.7 of Recruitment Notice CHSL-2024, "Persons with Disabilities candidates who claim to be permanently unfit to take the Typing Test because of a physical disability may, with the prior approval of the Commission, be exempted from the requirement of appearing and qualifying at such test, provided such a candidate submits 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 to be permanently unfit for the Typing Test because of a physical disability. In addition, such candidates must substantiate their claim by furnishing the relevant Medical Certificate in the prescribed format as per Annexure-XI to Annexure-XIII of the Notice of Examination, as applicable, at the time of Typing Test. Otherwise their claim for seeking exemption from Typing Test will not be entertained by the Commission.".

2. In terms of above provisions, the Orthopedically Handicapped candidates qualified for Tier-II from Maharashtra, Gujarat and Goa Region seeking exemption from appearing in Typing Test may, in their own interest send a request along with scanned copies of following documents on email ID: **contactsscwr@gmail.com** , ***latest by 11.11.2024.***

(i) **Medical Certificate** seeking exemption in prescribed format (**Annexure XIV** of the notice of Examination) from the competent Medical Authority, i.e., the Civil Surgeon of a Government Health Care Institution.

(ii) **Annexure XI to Annexure XIII**

(iii) ***Undertaking*** *as per the format annexed to this notice (Copy enclosed).*

It is being reiterated that candidates submitting form Annexure XI to XIII and XIV should ensure that the certificate has the following:

(a) Issued by Civil Surgeon

(b) Clearly indicating how the disability interferes with Typewriting.

(c) Brief description of disabilities.

(d) Percentage of disabilities

3. The OH candidates are required to produce all these documents at the center of his/her examination. **Candidates are not supposed to absent themselves from this exam.**

Staff Selection Commission (WR)
29.10.2024

Annexure

UNDERTAKING

I_____, Roll No. _____ am a candidate of CHSLE 2024 Examination and would like to avail exemption in typing test, in accordance with Para 13.9.7.7.7 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 (**Annexure XIV**) of notice of examination, 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 XI** to **Annexure XIII** 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.

SIGNATURE.....

NAME OF CANDIDATE.....

ROLL NO.....

DATE.....

वचनपत्र

मै..... रोलनंबर_____ CHSLE 2024 परीक्षा का उम्मीदवार हूँ और परीक्षा के नोटिस के पैरा 13.9.7.7.7 के अनुसार, टाइप टेस्ट से छूट का लाभ लेना चाहता हूँ, क्योकि मै शारीरिक विकलांगता के कारण टाइपिंग देने में स्थायी रूपसे अनफिट हूं। मैं परीक्षा के नोटिस के निर्धारित प्रारूप **(अनुबंध - XIV)** में अपेक्षित प्रमाणपत्र की एक प्रति जोकी सक्षम चिकित्सा प्राधिकारी जोकी सरकारी स्वास्थ्य देखभाल संस्थान का सिविल सर्जन के द्वारा जारी किया गया हो, साथही निर्धारित प्रारूप में प्रासंगिक चिकित्सा प्रमाणपत्र परीक्षा विज्ञप्ति के अनुलग्नक **XI** से **XIII** के अनुसार संलग्न कर रहा हूँ।

मैं यह भी वचन देता हूं कि मैं आयोग के समक्ष दस्तावेज सत्यापन के दौरान इन सभी दस्तावेजोंको मूलरूप में प्रस्तुत करूंगा। यदि मैं इनको प्रस्तुत करने में विफल रहता हूं, तो आयोग इस परीक्षा के लिए मेरी उम्मीदवारी रद्द कर सकता है और आयोग के फैसले के खिलाफ मेरा कोई दावा नहीं होगा।

हस्ताक्षर .....

अभ्यर्थीकानाम.....

अनुक्रमांक .....

दिनांक .....

ANNEXURE-XIV

Form of Medical Certificate to be produced by the Persons with Benchmark Disabilities candidates who seek exemption from appearing in the Typewriting Test

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:

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	of Issue	ls 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.	Mentalillness			
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

(Authorised 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