

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: Orthopaedically Handicapped (OH) 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 Orthopaedically Handicapped (OH) 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 centre 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.....

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 overall 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
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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

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			

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	Is 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

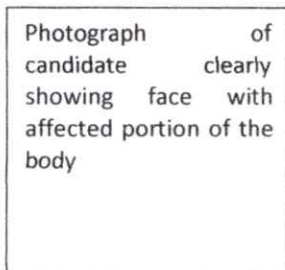
ANNEXURE-XIV

**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:

Signature of candidate:

Name:

Roll Number:

वचनपत्र

मैं..... 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, क्योंकि मैं शारीरिक विकलांगता के कारण टाइपिंग देने में स्थायी रूपसे अनफिट हूँ। 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 हूँ कि मैं आयोग के समक्ष दस्तावेज सत्यापन के दौरान इन सभी दस्तावेजोंको मूलरूप में प्रस्तुत करूंगा। यदि मैं इनको प्रस्तुत करने में विफल रहता हूँ, 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