Staff Selection Commission (KKR)
Bangalore
F.No. ST-109/2/2024-Nomination

Skill Test for Combined Higher Secondary (10+2) Examination, 2024

Subject: PwD candidates of CHSLE-2024 seeking exemption from appearing in Typing Test

As per Corrigendum-I issued dated 27.8.2024 with respect to the above recruitment Notice of CHSLE-2024 (Para No. 13.9.7.7.7), the Persons with Disability (PwD), who are otherwise qualified to hold the post(s) and who are certified as being unable to type by the competent Medical Authority, i.e., the **Civil Surgeon of a Government Health Care Institution**, may be exempted from passing the typing test. Such certificate shall be submitted in the prescribed format **(Annexure-XIV)**. The term 'Persons with Disability (PwD)', in this case, does not cover those who are visually handicapped or who are hearing handicapped but covers only those whose physical disability permanently prevents them from typing. 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. The candidates in their own interest may send the scanned copies of the following documents on email ID: adselpost.kkr.ssc@gov.in, ***latest by 30th October, 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. It is again reiterated that candidates submitting Annexure-IV should ensure that the certificate has following:

(a) Issued by Civil Surgeon.
(b) Clearly indicate how the disability interfere with Typewriting.
(c) Brief description of disabilities.
(d) Percentage of disabilities.

(ii) **Certificate of Disability** in the prescribed format as per Annexure-XI to Annexure-XIII of the notice of Examination, as applicable.

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

3. The decision of the competent authority on grant of exemption will be conveyed before the day of Skill Test.

4. Please note that as per Para No. 13.9.7.6.1 of CHSE-2024 Notice, 'exemption' is **not** allowed for the post of Data Entry Operator.

5. The candidates are required to produce all these documents **in original** before the Commission or the User Department, if they are called for document verification.

SSC (KKR)
Date: 16.10.2024

UNDERTAKING

I_____, Roll No. _____ am a candidate of CHSLE 2024 Examination and would like to avail exemption from the requirement of appearing and qualifying in type 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 A**nnexure 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 or the User Department. If I fail to produce the same, the Commission or the User Department may cancel my candidature for this examination and I will have no claim against their decision.

SIGNATURE .....

NAME .....

ROLL NO .....

DATE .....

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) ----------

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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