

Staff Selection Commission
(Northern Region)

Important Notice

Attention: Candidates of CGL-2022 examination seeking exemption from appearing & qualifying in DEST

DEST for CGLE, 2022 will be conducted by the Commission from 02.03.2023 to 07.03.2023 (except 04.03.2023 & 05.03.2023) along with Paper-I in Session-II. Relevant instructions pertaining to exemption from DEST are as follows :-

OH candidates are eligible for exemption from attempting DEST, provided such candidates submit a Certificate in the prescribed format (Annexure-XVI) 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. However, such exemption is not available for the posts where either Computer Proficiency is prescribed (as mentioned at Para 13.8.10) or where DEST is prescribed (as mentioned at Para 13.8.11.4) except for the post of the Tax Assistant in CBDT, for which exemption from attempting DEST is available. All other PwD candidates are not eligible for exemption from DEST.

The candidates have to **report at the exam centre/venue** for seeking exemption from appearing & qualifying in DEST on the date of their DEST along with duly filled **Annexure-XVI, Undertaking** (mentioned as annexure) and their medical certificate from notified Medical Authority (**Annexure XIII to XV**), whichever is applicable, as per Notice of the exam. (Relevant annexure are attached with this notice)

Further, the candidates are required to produce all these documents in original at the time of document verification. If any candidate fails to produce the same, candidature of such candidates will be cancelled and they will have no claim against any posts.

All the concerned candidates of CGLE, 2022 are directed to go through Notice dated 17.09.2022 pertaining to CGLE, 2022 for further details.

Under Secretary (EA)

Dated : 24/02/2023

Enclosures:- As under

UNDERTAKING

I _____, Roll No. _____ am a candidate of CGL 2022 Examination and would like to avail exemption from the requirement of appearing and qualifying in DEST, in accordance with Para 13.8.11.6 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- XVI**), issued by competent medical authority i.e. a civil surgeon of a Government health care institution along with relevant medical certificate in prescribed format.

I also undertake that I will produce all these documents in original at the time of document verification. If I fail to produce the same, my candidature will be canceled and I will have no claim against any posts.

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. Thalassaemia
- 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

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 – .

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: