Annexure A

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 B1

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

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.

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 C

NATIONAL INSTITUTE OF TECHNICAL TEACHERS TRAINING AND RESEARCH
TARAMANI, CHENNAI – 600 113.

I _____, am a candidate who has applied for the post of Junior Secretariat Assistant (Hindi Typist) would like to avail exemption from the requirement of appearing and qualifying in Typing Test, in accordance with notice of examination, as I am permanently unfit to take the Typing Test because of Physical disability. I am herewith attaching a copy of requisite certificate issued by competent Medical Authority i.e., a civil surgeon of a Government Health Care Institution. I also undertake that I will produce all these documents in original during document verification.

Signature: .....

Name of Candidate: .....

Application No.: .....

Date: .....