



स्वातंत्र्याचा अमृत महोत्सव



महाराष्ट्र राज्य माध्यमिक व उच्च माध्यमिक शिक्षण

मंडळ, कोल्हापूर विभागीय मंडळ, कोल्हापूर

५३९, राजेंद्रनगर, कोल्हापूर-४१६ ००४.

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दिनांक - 22 / 02 /2023

प्रति,

मुख्याध्यापक,

सर्व मान्यताप्राप्त माध्यमिक शाळा,

सातारा / सांगली / कोल्हापूर.

विषय :- माध्यमिक शालान्त प्रमाणपत्र (इ.१०वी) व उच्च माध्यमिक प्रमाणपत्र (इ.१२वी) परीक्षा मार्च २०२३ दिव्यांग विद्यार्थ्यांस सवलती देणेबाबत..

संदर्भ :-१. शासन निर्णय संकिर्ण २०१७/(११८/१७) एम.डी.६ दि.१६ ऑक्टोबर २०१८

२. राज्यमंडळ, पुणे यांचे क्र.रा.मं./परीक्षा-५/८३५ दि.१७/०२/२०२३ चे पत्र

३. राज्यमंडळ, पुणे यांचे क्र.रा.मं./परीक्षा-५/६२१८ दि.१०/११/२०२२ चे पत्र

उपरोक्त संदर्भीय विषयास अनुसरून आपणांस कळविण्यात येते की, उच्च माध्यमिक प्रमाणपत्र (इ.१२वी) व माध्यमिक शालान्त प्रमाणपत्र (इ.१०वी) फेब्रुवारी-मार्च २०२३ परीक्षेकरिता प्रविष्ट होणाऱ्या दिव्यांग विद्यार्थ्यांस जादा वेळ सवलत तसेच लेखनिक मिळणेबाबत शाळा / कनिष्ठ महाविद्यालयामार्फत या कार्यालयास प्रस्ताव प्राप्त होतात.

शासन निर्णय संकिर्ण २०१७/(११८/१७) एम.डी.६ दि.१६ ऑक्टोबर २०१८ च्या शासन निर्णयानुसार दिव्यांग विद्यार्थ्यांना देय असणाऱ्या सवलती देण्यात येतात. प्रचलित पध्दतीमध्ये अंध विद्यार्थी, कर्णबधीर, मूकबधीर, अस्थिव्यंग/ बहूविकलांग, अध्ययन अक्षमता, आजार असलेल्या विद्यार्थ्यांकरिता विहित नमुना फॉर्म उपलब्ध आहेत, मात्र इतर आजार असलेल्या विद्यार्थ्यांकरिता नमुना फॉर्म उपलब्ध नसल्याने जिल्हा शल्य चिकित्सक, जिल्हा सामान्य रुग्णालय यांच्या स्वाक्षरी व शिक्का घेण्यासाठी दिव्यांग विद्यार्थी गेल्यास त्यांना स्वाक्षरी व शिक्का मिळण्यास अडचणी निर्माण होत आहेत.

दिव्यांग विद्यार्थ्यांना विहित नमुना फॉर्म नसल्यामुळे सोयी, सवलती मिळण्यास अडचणी निर्माण होत आहेत त्यामुळे दिव्यांग व्यक्ती हक्क अधिनियम २०१६ नुसार दिव्यांगत्व तपासणी, मुल्यमापन व प्रमाणपत्र वितरणासाठीच्या मार्गदर्शक सुचना दि.१४ सप्टेंबर २०१८ च्या शासन निर्णयातील संस्थांनी दिव्यांग विद्यार्थ्यांना दिव्यांगत्वाचे कायमस्वरुपाचे किंवा काही आजारात भविष्यात बदल होणार असेल तर विहित मुदतीचे प्रमाणपत्र दिलेले असते, सदर प्रमाणपत्राची संबंधित मुख्याध्यापक / प्राचार्य यांनी प्रमाणित करून प्रस्ताव सादर करणे आवश्यक आहे. केवळ विहित नमुना फॉर्म नसल्याने कोणताही दिव्यांग विद्यार्थी सोयी सवलतीपासून वंचित राहणार नाही याची दक्षता घ्यावी.

सोबत १ ते २१ आजाराचे प्रमाणपत्र देणाऱ्या संस्थांची यादी असलेला तक्ता सुलभ संदर्भासाठी जोडण्यात आलेला आहे. तसेच दिव्यांग विद्यार्थी सोयी व सवलतीसाठी आवश्यक कागदपत्रांची यादी खालीलप्रमाणे आहे.

अक्र	लेखनिक, जादा वेळ, सवलतीचे गुण	जादा वेळ, सवलतीचे गुण
१	शाळेचे स्पष्ट शिफारस पत्र - कोणती सवलत हवी आहे याचा स्पष्ट उल्लेख पत्रात असावा.	शाळेचे स्पष्ट शिफारस पत्र - कोणती सवलत हवी आहे याचा स्पष्ट उल्लेख पत्रात असावा.
२	दिव्यांग प्रमाणपत्राची प्रमाणित प्रत	दिव्यांग प्रमाणपत्राची प्रमाणित प्रत
३	मंडळाचा विहीत नमुन्यातील दिव्यांग फॉर्म भरून विद्यार्थ्याचा फोटो लावून त्यावर डॉक्टरांची स्वाक्षरी / शिक्यासह व सिव्हील सर्जन यांची प्रतिस्वाक्षरी	दिव्यांग नमुना फॉर्म १ ते ५ - जिल्हा चिकित्सक यांची स्वाक्षरी असलेला
४	लेखनिक आवश्यक असल्यास इ.९ वीचा त्याच शाळेतील विद्यार्थी घेणे आवश्यक १. लेखनिकाचा फोटोसह बोनोफाईड प्रमाणपत्र २. लेखनिक हमीपत्र ३. लेखनिकाच्या पालकाचे हमीपत्र इ.	

आपल्या शाळा व कनिष्ठ महाविद्यालयातील दिव्यांग विद्यार्थ्यांचे प्रस्ताव सादर करताना वरील निकषांव्यतिरिक्त अन्य कोणत्याही कागदपत्रांची मागणी करू नयेत तसेच दिव्यांग विद्यार्थी सवलतीपासून वंचित राहणार नाही याची आपण दक्षता घ्यावी.



(डी.एस.पोवार)

विभागीय सचिव,

कोल्हापूर विभागीय मंडळ, कोल्हापूर

प्रत माहितीस्तव तथा आवश्यक कार्यवाहीसाठी -

सर्व केंद्रसंचालक - इ.१० वी व इ.१२वी मार्च २०२३ परीक्षेसाठी परीक्षा सुरु होण्यापुर्वी ऐनवेळी एखादा दिव्यांग विद्यार्थी प्रविष्ट होण्यासाठी आपल्या परीक्षा केंद्रावर उपस्थित राहीला तर वरील निकषानुसार त्याला देय असणाऱ्या सर्व सवलती देण्यात याव्यात व त्याचा दिव्यांग प्रस्ताव या कार्यालयास शाळेमार्फत यथावकाश सादर करण्यास सुचित करावे.

Annexure:-6

Chart Showing the institutes to be designated to issue disability certificate for different disability type.

Serial No.	Type of Disability	Whether it is possible to issue certificate ?										Specialist /Technician necessary for Certification	Remark if any
		Govt/Municipal Medical college	District Hospital	General Hospital	Sub - District Hospital	Rural Hospital*	Orthopedic Hospital	AYINIHI Bandra	AIIPMR Hajiali	Non Traching Municipal hospitals			
1	Blindness	Yes	Yes	Yes	Yes	No	No	No	No	Yes		Optthalmologist/ Opthalmic officer	Optthalmologist should be compulsory
2	Low-vision	Yes	Yes	Yes	Yes	No	No	No	No	Yes		Optthalmologist/ Opthalmic officer	Optthalmologist should be compulsory
3	Leprosy Cured Patients	Yes	Yes	Yes	No	No	No	No	No	No		Physician/ Dermatologist	Also at Leprosy Hospital Kondhwa Pune
4	Hearing Impairment (Deaf and hard of Hearing)	Yes	Yes	Yes	No	No	No	Yes	No	No		ENT Surgeon/ Audiologist	AYINIHI Bandra is final authority in dispute cases
5	Locomotor Disability	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes		Orthopedic Surgeon	AIIPMR Hajiali has domain of all the state. For RH Orthopedic Surgeon should be made available on deputation
6	Dwarfism	Yes	Yes	Yes	No	No	No	No	No	No			
7	Intellectual disability	Yes	Yes	Yes	No	No	No	No	No	No			
8	Mental illness	Yes	Yes	Yes	No	No	No	No	No	No			
9	Autism Spectrum Disorder	Yes	Yes	Yes	No	No	No	No	No	No			
10	Cerebral Palsy	Yes	Yes	Yes	No	No	No	No	No	No		Psychiatrist and Physician	Psychiatrist and Physician is must to issue these certificates
11	Muscular Dystrophy	Yes	Yes	Yes	No	No	No	No	No	No			
12	Chronic Neurological Conditions	Yes	No	No	No	No	No	No	No	No		Neurologist	
13	Specific Learning Disabilities	Yes	Yes	No	No	No	No	No	No	No		Paediatrician/Psychiatrist/Clinical Psychologist and Special Educator	Special Educator to be taken from Education Department

Annexure:-6

Chart Showing the institutes to be designated to issue disability certificate for different disability type.

Serial No.	Type of Disability	Whether it is possible to issue certificate ?										Specialist /Technician necessary for Certification	Remark if any
		Govt/Municipal Medical college	District Hospital	General Hospital	Sub - District Hospital	Rural Hospital*	Orthopedic Hospital	AYINHI Bandra	AIIPMR Hajiali	Non Traching Municipal hospitals			
14	Multiple Sclerosis	Yes	Yes	No	No	No	No	No	No	No		Physician must be available	
15	Speech and Language Disability	Yes	Yes	No	No	No	No	Yes	No	No	ENT Surgeon/ Audiologist/ Speech Therapist	AYINHI Bandra is final authority in dispute cases	
16	Thalasemia	Yes	Yes	No	No	No	No	No	No	No	Physician	Electrophoesis , Solubility test must be available	
17	Haemophilia	Yes	Yes	No	No	No	No	No	No	No			
18	Sickle Cell Anemia	Yes	Yes	No	No	No	No	No	No	No			
19	Multiple Disabilities including deaf blindness	Yes	Yes	Yes	No	No	No	No	No	Yes	Optalmologist/ ENT Surgeon and others as the case may be	Two or More Specialists of different specialities must be available	
20	Acid Attack victims	Yes	Yes	Yes	No	No	No	No	No	No	Surgeon/Plastic Surgeon (optional)	Surgeon / plastic Surgeon needed to certify	
21	Parkinson's disease	Yes	No	No	No	No	No	No	No	No	Neurologist /Physician	Neurologist / Physician Must be available.	

* For Rural Hospital certificates can be issued depending on availability.

* For Rural Hospital certificates can be issued depending on availability of Specialist.

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FORM -I
MEDICAL CERTIFICATE FOR
THE VISUALLY IMPAIRED CANDIDATE

Attested
Photograph

Certified that, I Dr. _____

Registration No. _____ have this _____ day of _____ year 20 _____,
examined the candidate whose particulars are given below :

1. Name of the Candidate
 2. Sex
 3. Approximate Age
 4. Identification mark
 5. (a) Father's Name
 - (b) Mother's Name
 6. Extent of residual vision, if any
- Right eye
Left eye
7. On set of visual impairment (Please state whether visual impairment is from birth or acquired later. If it has been caused afterwards, the age and cause of visual impairment may be indicated) (For the purpose of concessions granted to visually impaired candidates, visually impaired are those who suffer from either of the following.)
 - (a) Total absence of sight
 - (b) Visual acuity not exceeding 6/60 or 20/200 (Snellen) in the better eye with correcting lenses.
 - (c) Limitation of the field of vision subtending angle of 20 degrees or worse)
 8. Please mention the percentage of disability and state clearly whether the candidate is visually impaired who can be considered for the purpose of giving concessions, granted by the Board to Visually Impaired Candidate.

Signature of Candidate

Place :

Date :

Signature of Ophthalmologist

Designation :

Office Stamp :

Address :

★ Countersigned by Civil Surgeon and Date :

School Index No. / Jr. College Index No. :

Signature of Head Master/Principal and Stamp :

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Attested
Photograph

1. Name of the Candidate :
2. Sex :
3. Approximate Age :
4. Identification mark :
5. (a) Father's Name :
(b) Mother's name :
6. An estimate of the residual hearing, if any, and the basis on which this estimate has been arrived at - : (a) Right ear :
(b) Left ear :
7. Onset of deafness (Please state whether deafness is from birth or acquired later. If it has been caused afterwards, the age and cause of deafness may be indicated) :
(For the purpose of concessions granted to hearing impaired candidates, hearing impaired are those, in whom the sense of hearing is non-functional for the ordinary purposes of life. Generally loss of hearing at 60 decibels or above at 500, 1000, 2000 frequencies will make residual hearing non-functional)
8. Please mention the percentage of disability and state clearly whether the candidate is hearing impaired for the purpose of giving concessions, granted by the Board to hearing impaired Candidates :
9. Please enclose audiogram chart :

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FORM -III
MEDICAL CERTIFICATE IN RESPECT OF AN ORTHOPEDICALLY
(PHYSICALLY) HANDICAPPED OR SPASTIC CANDIDATE

For the purpose of concessions granted to orthopedically (physically) handicapped or spastic, the Orthopedically (Physically) Handicapped or Spastic are those who have physical defect or deformity which causes an interference with the normal functioning of bones, muscles and joints.

Certified that, I Dr. ----- Registration
No. ----- have this ----- day of ----- year 20 -----
-, examined the candidate whose particulars are given below and that he/she falls within the above
definition :

1. Name of the Candidate :
2. Sex :
3. Approximate Age :
4. Identification mark :
5. (a) Father's Name :
(b) Mother's Name :
6. A. Nature of disability :
(Tick relevant from following List)
POST-POLIO-PARALYSIS, HEMIPLEGIA, QUADRAPLEGIA,
MALUNITIED, FRACTURE, NERVE PARALYSIS, UPPER
EXTREMITY, LOWER EXTREMITY, LIMP, PAINFUL,
SHORTENING, DEFORMITY, CONGENITAL, ACQUIRED,
ABOVE KNEE, BELOW KNEE, HIP HEMIPELVECTOMY,
SYMES, CHEOPARTS, WRIST, FINGERS, BELOW ELBOW,
ABOVE ELBOW, SHOULDERS, FORE QUARTER,
UNILATERAL, BILATERAL
- B. Extent of disability :
Estimate in percentage (mc.Bridge Scale)
On Anatomical, Functional, (Patients Assessment,
Examiner's Assessment)
Percentage (Please mention the percentage of disability
and state whether the candidate is Orthopaedically
(Physically) Handicapped or Spastic who can be
considered for the purpose of giving concessions
granted by the Board to Physically Handicapped /
Spastic candidate
- C. Use of Applicant : (Tick relevant from following list) :
Calliper, Crutch, Above Knee, Below Knee, Prosthesis,
Cane, Unilateral, Bilateral, Above Elbow, Below Elbow,
Hemipelvectomy, Shoulder, Dis-Articulation

FORM NO - 3

- D. Any operation done or indicated :
E. Photograph (Attested) to be pasted below
to show the nature of disability and any
appliance if used.
7. Any other particulars to clarify that nature and extent
of disability that the Surgeon might like to point out.:

**Post Card Size
(Full Body Photograph)**

Signature of Candidate

Place :

Date :

Signature of Orthopaedic Surgeon

Designation :

Office Stamp : *

Address :

* Countersigned by Civil Surgeon and Date :

School Index No. / Jr. College Index No. :

Signature of Head Master/Principal and Stamp :

FORM -IV
MEDICAL CERTIFICATE FOR THE CANDIDATES
HAVING LEARNING DISABILITY

Attested
Photograph

Certified that, we, Dr. ----- Regd. No. ----- and Dr./
Special educator ----- Regd. No./Licence No. ----- have, examined
the candidate, whose particulars are given below, on the following dates independent of each other :

1. Name of the Candidate :
 2. Sex :
 3. Age in years and months :
 4. a) Identification mark :
 - b) Signature of the Candidate :
 5. (a) Father's Name :
 - (b) Mother's Name :
 6. Nature and percentage of the disability :
- (Based on the tests devised by the Board comprising of
a Neurologist, Child Psychologist and Special Educator)
Please indicate the disability with a (✓) (tickmark)

- | | |
|-----------------|--------------------------|
| (a) DYSLEXIA | <input type="checkbox"/> |
| (b) DYSGRAPHIA | <input type="checkbox"/> |
| (c) DYSCALCULIA | <input type="checkbox"/> |

We further recommend the following concessions to be permitted for the same.

Dyslexia :

The permission to conduct the examination with the use of a writer who will read out the question paper and take a dictation of the answer and the permission to offer Two Languages (one mother tongue / medium of instructions and the other second language) instead of three languages. For third language option of Work Experience according to Scheme of Subjects for these candidates may be granted.

Dysgraphia :

The permission to use a writer for answering the paper and the permission to offer Two Languages (one mother tongue / medium of instructions and the other Second Language) instead of three languages. For third language option of Work Experience according to Scheme of Subjects for these candidates may be granted.

Dyscalculia

The permission to opt Arithmetic for Std. VII (75 marks) and Work Experience (75 Marks) instead of Mathematics (Algebra and Geometry). No concession regarding any other subjects.

Signature of the examining neurologist and date :
Signature of the examining Paediatrician / :
Special Educator and Date :
Countersigned by Civil Surgeon and Date :
Signature of Head Master/Principal and Stamp :
School Index No. / Jr. College Index No. :

FORM - V

Medical Certificate for the Austistic Candidate

Attested
Photograph

Certified that, I Dr. _____

Registration No. _____ Dated _____ have

examined the candidate whose particulars are given below :

1. Name of the Candidate :
2. Sex :
3. Age/Approximate Age :
4. Identification Mark :
5. (a) Father's Name :
(b) Mother's Name :
6. Extent of autism
7. Please mention the percentage of disability
and state clearly whether the candidate is autistic
and eligible to get concession granted
by the Board to Autistic candidate :

Signature of the Candidate :

Place :

Date :

* Countersigned by Civil Surgeon and Date :

School Index No. / Jr. College Index No. :

Signature of the Head Master / Principal and Stamp :

Signature of Specialized Doctor

Designation

Office Stamp

Address :

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