



ଓଡ଼ିଶା ବିଦ୍ୟୁତ୍ ଶକ୍ତି ସଂଚାରଣ ନିଗମ ଲି.ଠ.

ODISHA POWER TRANSMISSION CORPORATION LIMITED

(A Government of Odisha Undertaking)
Regd. Office: Janpath, Bhubaneswar - 751022

Conduct of Computer Based Test for recruitment to various posts In OPTCL

DECLARATION BY THE LOW VISION/OH CANDIDATE

I _____ S/o, W/o, D/o _____
R/o _____ Roll Number: _____ for the examination
for the post of _____ (Post Code :- _____) exam schedule on
_____ session _____ hereby declared that Mr.
/MS. _____ S/o, W/o, D/o _____,
R/o _____ has agreed on my request to act as my
scribe for the above online computer based test/ examination.

DECLARATION BY THE SCRIBE / WRITER

I _____ S/o, W/o, D/o _____
R/o _____ holder of identification _____ have agreed to
act as scribe for Mr./Ms. _____ S/o, W/o, D/o
_____ the Low Vision / OH candidate having Roll
No. _____ for the examination for the post of _____ (Post
Code: _____) exam schedule on _____ and Session _____.

I declared that my educational qualification as on date _____ is (Tick the box):

Under 10 th	10 th	10,+2	Graduate	Post Graduate

Space for pasting
recent passport
size photograph of
**Scribe to be cross
self-attested.**

Space for pasting
recent passport size
photograph of
**Candidate to be
cross self-attested.**

If the above declaration is found false, I shall be
solely responsible for the consequences and loss
suffered by the candidate.

Signature of Scribe

If the above declaration is found false, I shall be solely
responsible for the consequences. I am engaging the above
scribe at my own cost and risk. I understand that if the
declaration of the scribe is found false, I may be debarred from
the examination.

Signature of the Low Vision /OH Candidate

Note: The candidate & scribe should report at half hour before the normal reporting time at the Exam Centre for this purpose.

**Certificate regarding Physical limitation in an examinee to write / operate a
Computer**

This is to certify that, I have examined Mr./Ms./Mrs. _____
(name of the candidates with disability), a person with
_____ (nature and percentage of disability as mentioned in the
Certificate of Disability), S/o./D/o. _____ a resident of
_____ (Village/District/State) and to state that he/she has physical
limitation which hampers his/her writing / operating a computer capabilities owing to his/her
disability.

Signature

CDM & PHO/ Civil Surgeon/ Medical Superintendent of a Government Health Care Institution.

Name and Designation

Name of Government Hospital/Health care centre with seal

Place:

Date:

Note: Certificate should be given by a specialist of the relevant stream/disability (eg. Visual impairment - Ophthalmologist, Locomotor disability - Orthopaedic specialist/PMR).