ODISHA JOINT ENTRANCE EXAMINATION – 2026
(OJEE – 2026)

No: OJEE / 0672 **DATE: 09.11.2026**

Notice For Physically Challenged (PC)/PwBD Candidates wish to take part in the State Quota POSTGRADUATION COURSE [MD (Hom.)], POSTGRADUATION COURSE [MD/MS (Ayurvedic)]. counselling and Admission Process.

This is for the information to all State domicile participating candidates of PG Counselling 2026 who wants to apply under PwBD category that, the NCISM/NMC has issued the PwD Guidelines, namely **"Guidelines on Assessment of Persons with Benchmark Disabilities (PwBD) for Admission to the MBBS Course, 2026"**. Candidates having valid AIAPGET – 2026 RANK interested to take admission under **PC/PwBD** category in courses of **POSTGRADUATION COURSE [MD (Hom.)], POSTGRADUATION COURSE [MD/MS (Ayurvedic)]. of Govt colleges of the State under State Quota Seats** must follow the Public Notice given by NCISM dated:**27-08-2026**. In view of the PwD Guidelines forwarded by NMC, PwBD candidates participating in PG Counselling 2026 are advised to note the following points w.r.t obtaining Eligibility Certificate for the purpose of upcoming PG Counselling 2026, from Medical Assessment Board of OJEE:

1. Candidates who wish to claim seat under PwBD category are required to visit the Medical Assessment Board of OJEE at **LT- II, SCB Medical College, Kataka, Odisha on 11th November, 2026 10.00 AM** and submit following documents at the board to obtain the Eligibility certificate
    i. AIAPGET-2026 score card demonstrating eligibility for the PG course.
    ii. Permanent UDID card issued by the Department of Empowerment of Persons with Disabilities (Divyangjan) (DEPwD), Ministry of Social Justice and Empowerment, GoI.
    iii. **Self-certified affidavit** declaring his or her functional abilities in the format specified in Schedule-I which shall be verified by Medical Assessment Board during the course of assessment.
    iv. Self-Certification **Affidavit (Appendix-A)** and Affidavit specific to the candidate's disability category, in the prescribed format of NCISM/NMC as provided in Appendix-B to F.
2. The certificate will be generated by the center as per details of disability mentioned on the UDID card and affidavit submitted by the PwBD candidate and subject to fulfillment of eligibility criteria.
3. In case the UDID Card or Affidavit submitted by the candidate is found to be 'FAKE', the seat of the candidate will be 'CANCELLED'; and legal action will be taken against the candidate.
4. The Eligibility certificate will be valid for this academic session only.

The detail schedule will be notified later on the website www.ojee.nic.in. For the MCC public notice and other information candidates may visit https://ojee.nic.in/ or https://aaccc.gov.in/ug-counselling/

Decision of the Medical Board is final and binding. Final Admission to PC/PwBD category will be made only as per the recommendations of this Board.

Candidates failed to attend the Medical Board shall not be considered under Physically Challenged (PC) category under any circumstances.

*For other details, please visit**: www.ojee.nic.in***

Sd/-
Chairman, OJEE

Appendix – A

Self-Certification Affidavit

(To be filled by all applicants applying under PwBD Category)

Name of Candidate: _____

NEET Roll No.: _____

NEET Score: _____

UDID No.: _____

Disability Type:

- Locomotor
- Hearing
- Visual
- Cognitive/SLD/
- *Others: _____ (Please Specify)

Disability Percentage as per UDID card: _____%

Assistive Devices Used (If any): _____

1. Essential Functional Competencies:

Competency Area	Description	Candidate Declaration (✓ / X)
A. Communication	• I can communicate clearly and empathetically with people using assistive devices.	
B. Hearing	• I can hear and respond to speech in both quiet and noisy environments, with or without hearing aids or cochlear implants • I undertake to fulfill the eligibility criteria set under Form Appendix -B	
C. Dominant Hand Functionality	• I can write and hold instruments using my dominant or aided hand. • I undertake to fulfill the eligibility criteria set under Appendix -C and D	
D. Understanding / Communication	• I can follow and comprehend medical terminology and maintain social interaction. • I undertake to fulfill the eligibility set under Form Appendix -E	
E. Vision	• My vision improves to the percentage lower than	

	40%. • I can perform with the help of Low vision Aid. • I undertake to fulfill the eligibility criteria set under Form Appendix -F	

2. I hereby affirm that I possess the essential competencies and am capable of successfully undertaking the BAMS/BHMS course.
3. I am aware that any false declaration may result in revocation of my admission.

Deponent Signature: _____

Date:
Place:
Notarized by:

***Note: Persons with benchmark disabilities other than Locomotor/Visual/ Hearing/ SLD/ ASD/Mental Iliness will have to submit the self-certified affidavit at Appendix-A only (eg.: Blood disorders - Haemophilia, Thalassemia and Sickle cell disease Chronic Neurological Conditions etc.)**

Appendix – B

AFFIDAVIT

(HEARING IMPAIRMENT)

I, _____, aged _____ years, son/daughter of _____, resident of _____, holding a valid UDID Card No. _____ issued by _____ on _____, do hereby solemnly affirm and declare as follows:

I have hearing loss in:

- Right Ear
- Left Ear
- Both Ears
- Neither

2. I use:
   - Prescribed Hearing Aid
   - Cochlear Implant
   - None

3. I declare as under:

Sl. No.	Functional Ability regarding following Activities declared	Candidate Declaration (✓ / X)
1.	Communicate effectively using the above-mentioned assistive devices.	
2.	Engage in a conversation in a quiet and noisy environment.	
3.	Understand and respond to verbal instructions.	
4.	Carry out phone conversations.	

4. I hereby affirm that I possess the essential competencies and am capable of successfully undertaking the BAMS/BHMS course.
5. I am aware that any false declaration may result in revocation of my admission.

Deponent Signature: _____
Date: _____
Place: _____

Notarized by:

APPENDIX-C

AFFIDAVIT
(LOCOMOTOR DISABILITY)
{UPPER EXTREMITY- COORDINATED ACTIVITY}

I, _____, aged _____ years, son/daughter of _____, resident of _____, holding a valid UDID Card No. _____ issued by _____ on _____, do hereby solemnly affirm and declare as follows:

2. I declare that I am suffering from _____ Disability.

3. The condition causing this disability is diagnosed as ……

4. I am using/not using any assistive device/artificial limb etc.

5. I declare my functional ability in performing the basic Coordinated Activities as below:

Sl. No.	Functional Ability regarding following Activities declared	Candidate Declaration (✓ / X)
1.	Can you lift overhead objects and place them at the same place?	
2.	Can you touch tip of the nose with the tip of a finger?	
3.	Can you eat by yourself?	
4.	Can you groom, comb and plate by yourself?	
5.	Can you put on a shirt/kurta/upper garment on your own?	
6.	Can you clean yourself after toileting (Act of Ablution)?	
7.	Can you Drink water holding a Glass/tumbler?	
8.	Can you button/unbutton your clothes?	
9.	Can you put on trousers/pant/lower garment/Tie Nara, Dhoti, using the Zip as the case may be?	
10.	Can you hold a Pen/Pencil and write?	

6. I hereby affirm that I possess the essential competencies and am capable successfully undertaking the BAMS/BHMS course.
7. I am aware that any false declaration may result in revocation of my admission.

Deponent Signature:

Date:

Place:

Notarized by:

APPENDIX-D

AFFIDAVIT

(LOCOMOTOR DISABILITY)
{LOWER EXTREMITY-STABILITY COMPONENTS}

I, _____, aged _____ years, son/daughter of _____, resident of _____, holding a valid UDID Card No. _____ issued by _____ on _____, do hereby solemnly affirm and declare as follows:

2. I declare that I am suffering from _____ Disability.
3. The condition causing this disability is diagnosed as _____.
4. I am using/not using any assistive device/artificial limb etc.
5. I declare my ability to perform the following functions as below:

Sl. No.	**Functional Ability regarding following Activities declared**	**Candidate Declaration (✓ / X)**
1.	Can you bear weight and stand on both legs?	
2.	Can you bear weight and stand on your affected leg?	
3.	Can you walk on plain surfaces?	
4.	Can you sit on a chair by yourself?	
5.	Can you climb up stairs on your own?	
6.	Can you go downstairs on your own?	
7.	Can you take turn to the right and left side?	

6. I hereby affirm that I possess the essential competencies and am capable of successfully undertaking the BAMS/BHMS course.
7. I am aware that any false declaration may result in revocation of my admission.

Deponent Signature:

Date:

Place:

Notarized by:

APPENDIX-E

AFFIDAVIT

(MENTAL ILLNESS / SPEECH DISORDERS / SPECIFIC LEARNING DISORDER / AUTISM SPECTRUM DISORDER)

I, _____, aged _____ years, son/daughter of _____, resident of _____, holding a valid UDID Card No. _____ issued by _____ on _____, do hereby solemnly affirm and declare as follows:

2. I declare that I am suffering from _____ Disability.
3. The condition causing this disability is diagnosed as _____.
4. I am using/not using any assistive device/artificial limb etc.
5. I declare my ability to perform the following functions as below:

Sl. No.	**Description**	**Candidate Declaration (✓ / X)**
1.	I can communicate clearly and empathetically with people.	
2.	I can listen and respond to speech in both quiet and noisy environments.	
3.	I can follow instructions, comprehend required medical terminology, and maintain social interaction.	
4.	I can understand and respond to verbal instructions and can carry out phone conversations.	

6. I hereby affirm that I possess the essential competencies and am capable of successfully undertaking the BAMS/BHMS course.
7. I am aware that any false declaration may result in revocation of my admission.

Deponent Signature:

Date:

Place:

Notarized by:

APPENDIX-F

AFFIDAVIT

(VISUAL IMPAIRMENT)

I, _____, aged _____ years, son/daughter of _____, resident of _____, holding a valid UDID Card No. _____ issued by _____ on _____, do hereby solemnly affirm and declare as follows:

1. I have Visual Impairment in:
   - Left Eye
   - Right Eye
   - Both Eyes
   - Neither

2. I am using Low Vision Aid(s):_____

3. With the use of Low Vision Aid, I declare the fulfillment of following criteria:

Sl. No.	ALL MANDATORY CRITERIA FULFILLED WITH THE LOW VISION AID	Candidate Declaration (✓ / X)
1.	Best corrected visual acuity improves such that the visual disability becomes less than 40%.	
2.	The field of vision is > 40 degree in the eye which is using the LVA.	
3.	The LVA is hands free and suitable for everyday use.	

4. I hereby affirm that I can perform with the use of Low Vision Aid.
5. I am aware that any false declaration may result in revocation of my admission.

Deponent Signature:

Date:

Place:

Notarized by:

ELIGIBILITY CERTIFICATE
To be Issued by the Medical Assessment Board

1. Candidate Particulars

1. Name of Candidate: _____
2. Father's/Mother's/Guardian's Name: _____
3. Date of Birth: _____/_____/_____
4. Gender: _____
5. NEET Application Number: _____
6. Roll/Registration Number: _____
7. UDID Number: _____
8. Disability Certificate Number and Date: _____

2. Medical Assessment Board

1. Name of Medical Assessment Board: _____
2. Institution/Hospital: _____
3. Date(s) of Assessment: _____/_____/_____
4. Place of Assessment: _____

3. Nature of Disability

1. Category of Disability: _____

2. Medical Diagnosis: _____

3. Nature and Extent of Disability: _____

4. Percentage of Benchmark Disability (where applicable): _____%

Note: The determination of eligibility has not been made solely on the basis of the diagnosis, category of disability, or percentage of benchmark disability.

4. Functional Competency Assessment

The Medical Assessment Board has assessed the candidate with reference to the essential competencies prescribed under the Competency Based Medical Education (CBME) Curriculum.

The Board records the following findings:

_____

_____

_____

_____

5. Assessment of Reasonable Accommodation

The Medical Assessment Board has considered the requirement and feasibility of providing reasonable accommodation, assistive technology, or other support measures.

Accommodation(s) considered:

_____

_____

Accommodation(s) recommended (if any):

_____

_____

If no accommodation is recommended, reasons:

_____

_____

6. Assessment of Ability to Complete the BAMS/BHMS Course

The Medical Assessment Board is satisfied that the candidate:

☐ Is capable of successfully completing the BAMS/BHMS Course and acquiring the essential competencies prescribed under the CBME Curriculum.

☐ Is capable of successfully completing the BAMS/BHMS Course subject to the reasonable accommodation(s) specified above

☐ Is not capable of acquiring the essential competencies prescribed under the CBME Curriculum despite consideration of reasonable accommodation.

Reasons:

_____

_____

_____

7. Patient Safety Assessment

The Medical Assessment Board has evaluated whether the disability poses any demonstrable risk to patient safety.
Findings:

_____

_____

Where any risk has been identified, the Board records whether such risk can be mitigated through reasonable accommodation:

_____

_____

_____

8. Final Determination

After considering–

a) the candidate's demonstrated functional competency;

b) the feasibility of reasonable accommodation and assistive technology;

c) the ability to successfully complete the BAMS/BHMS Course and acquire the prescribed competencies; and

d) considerations relating to patient safety,

the Medical Assessment Board hereby certifies that the candidate is:

☐ **Eligible**

☐ **Eligible with Reasonable Accommodation**

Recommended Accommodation(s):

_____

_____

☐ **Ineligible**

Reasons:

_____

_____

_____

9. Declaration of the Medical Assessment Board

The Medical Assessment Board certifies that this determination has been made after conducting an individualized assessment based on objective medical and functional evidence, taking into account the essential competencies prescribed under the Competency Based Medical Education (CBME) Curriculum, the feasibility of reasonable accommodation and assistive technology, and considerations relating to patient safety. The determination has not been based solely on the diagnosis, category of disability, or percentage of benchmark disability.

10. Signatures

Name of Member	Designation	Signature
	Chairperson	
	Member	
	Member	
	Member	
	Member	

Date: _____/_____/_____

Place: _____

(Official Seal of the Medical Assessment Board)