Form No. 10-IA

[See sub rule (2) rule 11A]

Certificate of the medical authority for certifying 'person with disability', 'severe disability', 'autism', 'cerebral palsy' and 'multiple disability' for purposes of section 80DD and section 80U

Certificate No: …………….………..

Date: ……………………..…….…………

1. This is to certify that Shri./Smt./Ms. ……………………………………..……………
………………………………… son/daughter of Shri. …………………………………………….,
age ………. years male/female* residing at …………………………………………….….
……………………………………………………………………………………………………..,
Registration No. …………………………. is a person with disability/severe disability* suffering from autism/cerebral palsy/multiple disability*.

2. This condition is progressive/non-progressive/likely to improve/not likely to improve*.

3. Reassessment is recommended/not recommended after a period of ………………………………… months/years*.

Signature of Neurologist/Pediatric Neurologist/ Civil surgeon/Chief Medical Officer* :

Name :

Address of institution/government hospital :

Qualification/ designation of specialist :

SEAL

Signature/Thumb impression* of the patient :

Note: * Strike out whichever is not applicable.