FORM NO. 10-IA

[See sub-rule (2) of 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:

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*.

Sd/-
(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.