

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.