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