**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 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.