

**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 : \_\_\_\_\_

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.

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.