

FORM NO. 10-I

[See rule 11DD]

Certificate of prescribed authority for the purposes of section 80DDB

1. Name of the Patient :
2. Address :
3. Father's name :
4. Name and address of the person on whom the patient is dependent and his relationship with the patient :
5. Name of the disease or ailment (please see rule 11DD) :
6. For diseases or ailments mentioned in item (i) of clause (a) of sub-rule (I), whether the disability is 40% or more (Please specify the extent) :
7. Name, address, registration number and qualification of the specialist issuing the certificate, along with the name and address of the Government hospital [see rule 11DD(2)] :

Verification

This is to verify that I, Dr. s/o (w/o) Shri, in the case of the patient Shri/Smt./Ms. after considering the entire history of illness, careful examination and appropriate investigations, am of the opinion that the patient is suffering from disease/ailments during the previous year ending on 31st March,

I also certify (only in case of neurological disease that the extent of disability is more than 40%) (strike off, if not applicable).

I certify that the information furnished above is true to the best of my knowledge.

Date:

Place:

.....
Signature of Doctor
(Name and Address)

To be countersigned by the Head of the Government hospital, where the prescribed authority is a specialist with post-graduate degree in General or Internal Medicine.

Date:

Place:

.....
Signature of Doctor
(Name and Address)