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 (1), 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/ailment 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 _____ Signature

Place _____

_____

(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 _____ Signature

Place _____

_____

(Name and Address)