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*. Reassessment 3. is recommended/not recommended after period of months/years*. Sd/-(Neurologist/Pediatric Neurologist/Civil Surgeon/ Chief Medical Officer*) Address of Institution/Government hospital: Qualification/designation of specialist: SEAL Signature/Thumb impression* of the patient Note: *Strike out whichever is not applicable.