

**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 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.