## 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			Nois a
person with disability/severe disability*	suffering	from autism/ce	rebral palsy/multiple
disability*.			
<b>2</b> This and this is an end of the second se	/1:1 1	4	11*

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/y	vears*.					

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.