**FORM NO 10-IA**

***(See sub rule (2) of rule 11A)***

Certificate of medical authority for certifying ‘person with disability, ‘severe disability’. ‘Autism’, ‘cerebral palsy’ and ‘multiple disabilities’ for purpose of Section 80DD and Section 80U

Certificate No.\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. THIS is to certify that Mr/Miss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ son/daughter of Mr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ aged \_\_\_\_\_\_\_ years, male/female, residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Registration No. \_\_\_\_\_\_\_\_\_\_\_\_ is a person with disability/severe disability suffering from autism/cerebral palsy/multiple disabilities.

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.

(Neurologist/Pediatric Neurologist/Civil Surgeon/Chief Medical officer)

Name:

Address of Institution / Government Hospital:

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Qualification/ Designation of Specialist:

SEAL:

Signature / Thumb impression of the patient:

Note: The Principal rules were published under Notification No. SO 969 dated 26th March, 1962 which has been amended from time to time, the last such amendment were made vide Notification No. S.O.896 (E) dated the 28th June, 2005.