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)