

| Sl. No.<br>क्र. संख्या | NAME of OTHER SOURCE<br>अन्य स्रोत का नाम | AMOUNT of ASSISTANCE BEING AWARDED<br>सी गई सहायता राशि |
|------------------------|-------------------------------------------|---------------------------------------------------------|
| 1                      | DBCS                                      | 2,000/-                                                 |
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| DECLARATION BY APPLICANT: I hereby declare that all details in the form are True to the best of my knowledge. Any false statement will render my Application & ongoing assistance, if any, liable for discontinuation.<br>I solemnly confirm that assistance, if provided from Koshika Foundation, will be used only for the "purpose", as stated in this form, for which such assistance was requested by me.<br>I hereby confirm that I have not & will not in future, seek or reimburse, in part or in full, from any other source(s) employment/insurance company or the amount for which the assistance is requested.<br>If I have used or will use any other source(s) for the purpose of the assistance, I will inform the Hospital immediately.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:                           |  |
| AGREEMENT BY APPLICANT (attach 200 words):<br>1) By giving my signature or thumb impression on this form, I (Applicant) hereby agree & authorize Koshika Foundation and its Trustees to reproduce my name, address, photo & details of the "purpose", for which such assistance is requested, through any medium, including but not limited to verbal, print, electronic, for soliciting donations for Koshika Foundation and/or disseminating information about the activities/commitment. Such use of my photo & details can be made by Koshika Foundation before or after my treatment or fulfillment of the "purpose" for which assistance is being requested.<br>2) I (Applicant) further agree that any such use of my name, address, photo & details of the "purpose", for which such assistance is requested, will not automatically entitle me for receiving or obtaining the said assistance. The decision for granting and/or continuing the assistance will rest solely with the Trustees of Koshika Foundation, and their decision in this regard will be final and acceptable to me.<br>3) I agree to give access to all my records, including but not limited to medical records, to the Hospital for the purpose of providing the best possible medical care to me. I agree to provide all necessary information to the Hospital for the purpose of providing the best possible medical care to me. I agree to provide all necessary information to the Hospital for the purpose of providing the best possible medical care to me. |  | APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:                           |  |
| AGREEMENT BY HOSPITAL (attach 200 words):<br>By affixing hereunder, signature of our authorized authority for recommending the assistance from Koshika Foundation, we (Hospital) hereby affirm & accept following:<br>1) That we neither are providing nor will in future give of financial assistance from another NGO or any other source, for the same patient(s), as we are requesting to get from Koshika Foundation, in the extent that such assistance is granted by Koshika Foundation. If the requested assistance is not granted by Koshika Foundation, it pertains to the Hospital's responsibility to provide the same from any other source. This request is not intended to be a condition for the Hospital to make up the shortfall from another NGO or any other source. This request is not intended to be a condition for the Hospital to make up the shortfall from another NGO or any other source. This request is not intended to be a condition for the Hospital to make up the shortfall from another NGO or any other source.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                           |  |
| RECOMMENDATION FOR ACCEPTANCE:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                           |  |
| Date of Surgery: 06/12/23<br>Name of Patient: Dr. M.B. S. Khan<br>Name of Surgeon: Dr. M.B. S. Khan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | Name of Hospital: Koshika Foundation<br>Name of Surgeon: Dr. M.B. S. Khan |  |
| SIGNATURE OF TRUSTEE 1:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | SIGNATURE OF TRUSTEE 2:                                                   |  |