DEL-C1-19-07- 4937 APPLICATION FORM FOR ASSISTANCE (Healthcare) Koshika सहायता हेन् आवेदन प्रारूप (स्थास्था देखमाल) foundation APPLICATION No. APPLICATION DATE: 1931 Hailding block of the SHIPS HELD 03241 0169 24 MARKET FIRST NAME of APPLICANT: ADE-YEARS SHIT-HT SEX PRO अगन्तिक का नाम TYEAKS MALE FATHER'S SPOUSE S NAME (FATUER AHMAD AL चिता/माडुम्ब भार जान PRADEAU -2 2507 SOLIANIP PERMANENT RESIDENCE ADDRESS: FUT STREET, WIT OCCUPATION! DRIVER (FATHER) AXI MARRIED (Fourter) / UNMARRIED (STRATER) NA TOTAL ANNUAL INCOME 1. 20, 000 (FAMER) (Attach Proof of Income) कारत वार्तिक अवव (अस्य मा भाष्य समान) PAN NO. THE THE THEAT ARE YOU AN HITOME TAX ASSESSEE (Tick Anichever in applicable): Yes I No क्या आप आप का समा है होने महत्व भी पन पर गारी भा निराम सराचे हा । नही FAMILY DETAILS WHEN FROM 40 Sn:No: Name of Family Member Age (Years) Gender Relation with Applicant क्षान संस्कृत परिकार के आहरते का नाम अवदक्ष के माथ सम्बंध HARISH FAMER MOMER PROTYER AL MALE BANLO MALE BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable) महायामा कर तिली विश्वति आप Ration Card (Attack Copy) Any Other Basis/Proof SEE Card EWS Curtificate (Attuch Card Copy) (Artach Caroficate Copy) वापालिका करहे आर्थ जात को प्रमुख गा मधिनी होता के मीचे प्रमाण पत्र अन्य कोई साक्ष्य (प्रमाण पत्र की साथा प्रति ग्रांतम करें। come to all our six were with China an all non all store with PURPOSE" for REQUESTING ASSISTANCE पालीयता हेवू किये महे विन्ही का उद्देशमा Medical Reports/Prescriptions Attached St No अस्मताल/डॉक्टर में कार्य की वर्ष प्रतिवेदन सुची मंजान BY HER RETINOBLASTOMA DIAGNIDSW ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SQUACES इस उन्हेर में हुए गाँड कर नहांचा बिसी हर जार है सिया गा। है? AMOUNT of ASSISTANCE BEING AVAILED NAME OF OTHER SOURCE 5) Mb

DECLARATION by APPLICANT. Service and vince and the best of my knowledge. Any false statement will cender my Application & ongoing against 1) I hereby confirm that all details in this Form are True to me best of my knowledge. Any false statement will cender my Application & ongoing against the first the form are True to me best of my knowledge. Any false statement will cender my Application & ongoing against the first the form are True to me best of my knowledge.

I) I hereby confirm that all petals in this Form are transfer to be used only for the "purpose", as stated in this Form, for which such a behalf or rejective/cancellation.

2) I solemnly confirm that assistance, if repetied from Kostuka Foundation, will be used only for the "purpose", as stated in this Form, for which such as it is possible to the purpose of the purpose of

2) I solarmity confirm that essentiance, if the recommendation of the part of in full, from any other source/employer/insurance company, as 3) I have by optime that I have not \$ as her in future, avail of combursement, in part of in full, from any other source/employer/insurance company, as 3) I have by optime that I have not \$ as a substance a requested.

The which this assessment are requested. 3) (hereby confirm that i have not & section in name to section the section that any section the section that are a section to section the section that section tha

2) को द्वार के कामण होते. केरिया कार्यार में भी ने को में है, यह होता का आवार मा सबला दिस्सा किसी अन्य योगनियोग्डमां/मीमा कमानी में न को विका है और न हो मीच्छ से कुँछ। 3) में हुछ करता है कि किस कारणा हनू का उपने की माँ है, यह होता का आवार मा सबला दिस्सा किसी अन्य योगनियोग्डमां/मीमा कमानी में न को विका है और न ही मीच्छ से कुँछ।

1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and it's Trustees to 1) By affixing my signature or thanb implession on the contains of the "purpose", for which such assistance is requested/granted, through any userpublishiput-up/reproduce my naive, address, photo & details of the "purpose", for which such assistance is requested/granted, through any cherpothishiput-up/reproduce my native, address, photo & details of the pulciting donations for Koshika Foundation and/or disseminating information about #'s madium, including but not limited to versal, print, electronic, for spliciting donations for Koshika Foundation before or after my treatment or fulfillment of a resdium, including but not limited to serpal, print, electronic, for saniching Moshika Foundation before or after my treetment or fulfilment of the "purpose" activities achievements. Such use of my photo & details can be impde by Koshika Foundation before or after my treetment or fulfilment of the "purpose"

for which assistance is being imprested.

2) I (Applicant) further agree that any such use of my name, address, photo & details of the "purpose", for which such assistance is requested/granted. The decision for granting and/or continuing the assistance. 2) (Applicant) tunber agree that any such use of my name, accretion. The decision for granting and/or continuing the satisfacted will not accommissive soldle me terreceiving or continuing the satisfacted will not accommissive entire me.

ात के प्राप्त के अपने करकार मा अंगडे की छाप लगावर, में (आदेशक) अपने सन्तर्गत की पुन्त करता है एवं "मानिका फाटडेशन और उसके न्यासीयों " मो ऑक्टब्र करता है कि मेर जान, ात करता है जात कर करता है को "कोशका" पूरम् न्याती, थान चालना/या दूसरे उद्देश्य से जुडी गतिविधियों और उपलब्धियों के लिये किया भी प्रसार माध्यम में प्रशासि करने में लिए अधिकृत है। यर प्रपट का विवरण में इलाज के पहले या बाद में फरने के लिए "सोशिका फाउडेसन" व न्यामी अधिप्रमृत है।

2) है (अवोदक) इस बाद में महत्ता है कि मेर नाम, पता, फोटों और विवाश जो कि सहायता के उन्देश्यों से प्रार्थत है मुझे स्थतः सहायता का इकटार नहीं बनाता। इस सम्बंध से

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

मानंद हे हमाल मा बंगार या निराम

च्यानी

(MOTHER)

AGREEMENT by HOSPITAL (ERATIN SIT TOTAL)

By affixing herminder, signature of our Authorised Signatory for recommending this case/patient for financial assistance from Koshika Foundation, we

(Hospital) horeby affirm & account following

1) that we neither are presently nor will in future avail of financial assistance from another NGO or any other source, for the same patienticase, as we are that we define are presently for will in future avail or indicate essistance is granted by Koshika Foundation. If the requested assistance is not to make up the shortful from another MCO assistance is not granted. by Kostaka Foundation, in part or in full, then the Hospital reserves it's right to make up the shortfall from another NGO or any other source. This confirmation essentially states that the Hospital will not avail any duplicate assistance for the same patient/case from any other NGO or any other source.

2) The assistance from Koshika Foundation is only linabulal in nature. The choice of the treatment/procedure advised/conducted by the Hospital on the patient, is bessed on the arrangement between the patient & the Hospital, and is in no way influenced by Koshika Foundation. Hence, the Hospital will assume sole & complete responsibility of the treatment & it's outcome & safety of the patient, and Koshika Foundation will have no role or responsibility

इसमें अधिकृत, ह=गणी को और से पामले/पेगी को "कोशिका फाउन्डेशन" से लिनिय सहायता हेतु सिफारिश को जाती है, जिसे इस (इस्पतास) निम्न प्रकार से मान्य व स्थाबत करते हैं। 1) यह कि न तो वर्तमान और न ही पश्चिक में वितिष महापता किसी में स्थान या किसी अन्य स्वीत से उन्न ग्रेगी/मामशे में स्ते हैं, जैसे कि इसने "कॉलिका नास्केटर" में सिफारिशांतिकों। तका वो सम्बंध में "काशिका पाठन्द्रेशन" द्वारा मध्य बंतु कि है। यदि "कोशिका फाउन्देशन" द्वारा महायता विनीत आशिक/सकल बेतु मन्दुर नहीं किया बता है से अस्थान किसी अन्य में। सरक्ष्मी संस्था के किसी अन्य सन्तापन से सहापना लेने का जीधकार सुरक्षित रखना है। इस पृष्टि में स्पष्ट कहा जाता है कि अस्पताल दिवास सहर दक्क संगोत्समने हुई किसी

2 "कोशिका फाउन्हेंग्न" से तो गई सहायता कंपाल विजिय प्रकृति की है। तेगी पर हस्पताल होता दी गई सलाह या किये गये उपचारप्रक्रिया कर मुगव सेगी पूर्व हस्पताल

के बीम का निष्यु है और "कोशिका पनावर्षशन" हारा किसी प्रकार का कोई देशक नहीं है। इसीत्ये हस्यताल में ग्रेगी के इलाव मुख्य और आने वर्ष वर्ण है। इसीत्ये हस्यताल में ग्रेगी के इलाव मुख्य और आने वर्ष वर्ण है।

RECOMMENDED FOR ACCEPTENCE खोक्तों के लिए संस्तुति

Date of Surgery

DA CEHAVI GUPTA D MOS R/100745

Filliame Only plasty & Ocular Oncology Regn. No. with Stamp) डाक्टर का नाम च हस्ताक्षर व ग्रीज. न.

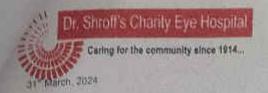
(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) ताम व पर रेसवात अधिकृत आँका

अस्तिस्य उपयोग प्रेत्

FOR INTERNAL USE of KOSHIKA FOUNDATION

SIGNATURE OF TRUSTEE 1 न्यासा इस्ताक्षर ।

SIGNATURE of TRUSTEE 2 त्यामा इस्ताधा ३





Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Abdul Samad- E/0324/0169

Estimate	cost of	treatment
Dr. Shroff's	Charity	Eye Hospital
Retinobi	astoma	Surgeries

Name		Abdul Samad	Address/ Phone:	Khas sultan pur.Mahuima, Ultar pradesh	
MRN		DEL-G-19-07-4937	Age/Sex	7 years	Male
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Aprox. Cost
1	2024-03-21	Examination under Anesthesia	2000	1	2000
	7	Total			2000

Best Regards

Dr. Sima Das

Director

Oculoplasty and Ocular Oncology Services

DR. SHROFF'S CHARITY EYE HOSPITAL

5027, Kedar Nath Road Daryaganj, New Delhi-110002 India Ph:- 011-4352 4444, 4352 8888, Fax : 011-43528816 E-mail : sceh@sceh.net, Website : www.sceh.net

OTHER CENTRES