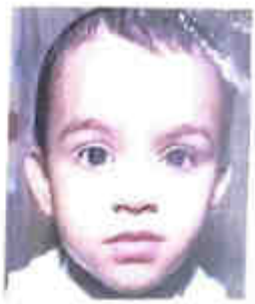
DEL-P-21-09-3637

APPLICATION FORM FOR ASSISTANCE (Healthcare)
सहायता हेतु आवेदन पत्र

Koshika Foundation

APPLICATION No.: आवेदन संख्या : E/0924/0182	APPLICATION DATE: आवेदन दिनांक 8/9/24
NAME of APPLICANT: आवेदक का नाम BABY VERONICA	AGE-YEARS: आयु वर्ष 3YEARS / GENDER: लिंग FEMALE
FATHER'S/SPOUSE'S NAME: पिता/पति का नाम PRASHANT (FATHER)	



PRESENT RESIDENCE ADDRESS: वर्तमान आवासीय पता
H-NO 52 POCKET-6 ROHINI COURTS, DELHI-110085

PERMANENT RESIDENCE ADDRESS: स्थाई आवासीय पता

OCCUPATION: व्यवसाय PRIVATE JOB (FATHER)

MARRIED (विवाहित) / ~~UNMARRIED~~ (अविवाहित) MA

TOTAL ANNUAL INCOME: कुल वार्षिक आय 1,80,000 (FATHER)

(Attach Proof of Income) (आय का संलग्न प्रमाण)

PAN No. स्थाई खाता संख्या:

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable)? क्या आप आयकर दाता हैं (जो लागू हो उस पर सही का चिन्ह लगाएं) Yes / हां ; No / नहीं

FAMILY DETAILS परिवार विवरण

Sr. No. क्रम संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ संबंध
1	PRASHANT	38	MALE	FATHER
2	RACHNA	30	FEMALE	MOTHER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)
सहायता के लिये निवेदन आधार

BPL Card (Attach Card Copy) गरीबी रेखा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आय आधारित प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) राशनकार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	Any Other Basis/Proof ~~अन्य कोई आधार~~

"PURPOSE" for REQUESTING ASSISTANCE:
सहायता हेतु किये गये निवेदन का उद्देश्य:

Medical Reports/Prescriptions Attached
अस्पताल/डॉक्टर से जारी की गई चिकित्सा सूची संलग्न

Sr. No. क्रम संख्या	
1	DIAGNOSIS - RETINOBLASTOMA
2	TREATMENT - EVA

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य के लिए कोई अन्य सहायता किसी अन्य स्त्रोत से लिया गया हो? NO

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्त्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशि
	NA	

DECLARATION by APPLICANT

AGREEMENT by APPLICANT (आवेदक द्वारा करार)

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

AGREEMENT by HOSPITAL (अस्पताल द्वारा करार)

RECOMMENDED FOR ACCEPTENCE

स्वीकृती के लिए संस्तुति

Date of Surgery		
9/9/24	Dr. CHHAVI GUPTA Adjunct Consultant, Oculoplasty and Ocular Oncology Services Regd. No. 100745 (Name, Designation & Regn. No. with Stamp) Dr. Shroff's Charity Eye Hospital	Dr. SIMA DAS Director Oculoplasty and Ocular oncology services Director, Medical Education Department Regd. No. 00297 (Name, Designation & Stamp of Authorised Signatory) Dr. Shroff's Charity Eye Hospital

FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 न्यासी दस्तखत 1	SIGNATURE of TRUSTEE 2 न्यासी दस्तखत 2

15-06-2023

Dr. Shroff's Charity Eye Hospital
Caring for the community since 1922

Dr. Shroff's Charity Eye Hospital
Delhi is Now NABH Accredited

30th September 2024

Dear Mr Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Baby. Veronica Veronica- E/0924/0182

Estimate cost of treatment Dr. Shroff's Charity Eye Hospital *Retinoblastoma Surgeries*					
Name		Baby Veronica Veronica	Address/ Phone:	H.no. 55, Pocket 6, Rohini courts,Delhi-110085	
MR N		DEL-P-21-09-3637	Age/Sex	3 years	Female
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Aprox. Cost
1	09/09/2024	Examination under Anesthesia	2000	1	2000
		Total			**2000**

Best Regards

Dr. Sima Das

Director

Oculoplasty and Ocular Oncology Services

DR. SHROFF'S CHARITY EYE HOSPITAL
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E-mail : sceh@sceh.net, Website : www.sceh.net