


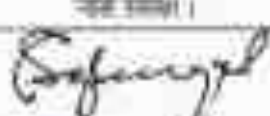
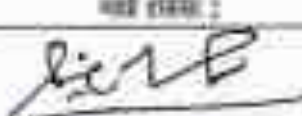


APPLICATION FORM FOR ASSISTANCE सहायता हेतु आवेदन पत्र		(Healthcard) (स्वास्थ्य कार्ड)	 Koshika FOUNDATION Building trust of life	
APPLICATION NO. आवेदन क्रमांक: E / 0125 / 0336	APPLICATION DATE आवेदन तारीख: 25/01/25			
NAME OF APPLICANT आवेदनकर्त्याचे नाव: YUQ TRIPATHI	AGE/YEARS (YE / YR) वय (वर्षे): 02 YEARS	SEX (SEX) लिंग: MALE		
FATHER'S/SPONSOR'S NAME पितृ/सहायकाचे नाव: AMIT TRIPATHI (FATHER)	PRESENT RESIDENCE ADDRESS (वर्तमान निवास पत्ता) VILL. POST AKHUNI A.P. - RAHAROLI, U.P. - 224206			
PERMANENT RESIDENCE ADDRESS (स्थायी निवास पत्ता)				
OCCUPATION (व्यवसाय): FARMER (FATHER)				
MARRIED (विवाहित) / UNMARRIED (अविवाहित)				
TOTAL ANNUAL INCOME (एकूण वार्षिक उत्पन्नाचे अंदाज):		(Attach Proof of Income) (आवेदन सोबत जोडा)		
PAN NO. (आय कराचे क्रमांक):		AND YOUR AN INCOME TAX RESIDENCE (Tuk where you is assistance) आय कराचे ठिकाण (जुलु जेथे तुमकें साहाय्यकें):		
YES / NO (होय / ना)		NO / YES (ना / होय)		
FAMILY DETAILS - (सुट्टी सदस्य)				
Sl. No. क्र. सं.	Name of Family Member सदस्याचे नाव	Age (Years) वय (वर्षे)	Gender लिंग	Relation with Applicant संबंध (आपल्यास)
1.	AMIT TRIPATHI	28	MALE	FATHER
2.	ROHIT TRIPATHI	15	MALE	FATHER
3.	KAMAKANT TRIPATHI	64	MALE	GRANDFATHER
4.	MEENA TRIPATHI	58	FEMALE	GRANDMOTHER
5.	KALPANA TRIPATHI	20	FEMALE	SISTER
BASED ON REQUESTING ASSISTANCE (Tuk where you is applying) आवेदन सोबत जोडा				
<input type="checkbox"/> BPL Card (आय कराचे क्रमांक) आय कराचे क्रमांक	<input type="checkbox"/> BWS Certificate (आय कराचे क्रमांक) आय कराचे क्रमांक	<input type="checkbox"/> Below Card (आय कराचे क्रमांक) आय कराचे क्रमांक	<input checked="" type="checkbox"/> Any Other (आय कराचे क्रमांक) आय कराचे क्रमांक	
"PURPOSE" FOR REQUESTING ASSISTANCE आवेदन सोबत जोडा				
Sl. No. क्र. सं.	Medical Report/Prescription Attached आय कराचे क्रमांक			
1.	DIAGNOSIS - RETINOBLASTOMA			
2.	TREATMENT - CHEM. RT.			
ASSISTANCE BEING AWARDED FOR SAME "PURPOSE" FROM OTHER SOURCES (Tuk where you is assistance) आय कराचे क्रमांक				
Sl. No. क्र. सं.	NAME OF OTHER SOURCES आय कराचे क्रमांक	AMOUNT OF ASSISTANCE BEING AWARDED आय कराचे क्रमांक		
	MR			

DECLARATION by APPLICANT (पेशेवर डॉक्टर को) (1) I hereby declare that all details in this Form are true to the best of my knowledge. Any false statement will render my Application & ongoing assistance, if any, liable for suspension/revocation. (2) I solemnly declare that assistance, if received from Kashiika Foundation, will be used only for the "purpose", as stated in this Form, for which such assistance was requested by me. (3) I hereby declare that I have not & will not in future, seek or seek assistance, in part or in full, from any other non-charitable/non-profit organization/company of the same or for which the assistance is requested. (4) If there comes a time when I am unable to pay for my treatment, I will not leave my work/occupation/education/other commitments, if any, until I am able to do so. (5) If you are unable to pay for your treatment, you will not leave your work/occupation/education/other commitments, if any, until you are able to do so. (6) If you are unable to pay for your treatment, you will not leave your work/occupation/education/other commitments, if any, until you are able to do so.	
AGREEMENT by APPLICANT (पेशेवर डॉक्टर को) (1) By affixing my signature in the above impression on this Form, I (Applicant) hereby agree & authorize Kashiika Foundation and its Trustees to use/authorize/authorize/representative name, address, and ID & details of the "purpose", for which such assistance is requested/planned, through any means, including but not limited to verbal, print, electronic, or any other means for Kashiika Foundation and/or disseminating information about its activities/commitments. Such use of my photo & details can be made by Kashiika Foundation before or after my treatment is followed if the "purpose" for which assistance is being requested. (2) I (Applicant) further agree that any such use of my name, address, photo & details of the "purpose", for which such assistance is requested/planned, will not automatically entitle me for receiving or continuing the said assistance. The decision for granting and/or continuing the assistance will rest solely with the Trustees of Kashiika Foundation and their decision in this regard will be final and acceptable to me. (3) I am aware that any such use of my name, address, photo & details of the "purpose" for which such assistance is requested/planned, will not automatically entitle me for receiving or continuing the said assistance. The decision for granting and/or continuing the assistance will rest solely with the Trustees of Kashiika Foundation and their decision in this regard will be final and acceptable to me. (4) I (Applicant) am aware that any such use of my name, address, photo & details of the "purpose" for which such assistance is requested/planned, will not automatically entitle me for receiving or continuing the said assistance. The decision for granting and/or continuing the assistance will rest solely with the Trustees of Kashiika Foundation and their decision in this regard will be final and acceptable to me.	
APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION: (पेशेवर डॉक्टर को)	
	
AGREEMENT by HOSPITAL (पेशेवर डॉक्टर को) By affixing my/our signature of our Authorized Signatory by recommending this application for financial assistance from Kashiika Foundation, we (Hospital) hereby affirm & accept following: (1) that we neither are presently nor will in future seek or seek financial assistance from another NGO or any other source, for the same patient/condition, as we are requesting to get from Kashiika Foundation, to the extent that such assistance is granted by Kashiika Foundation. If the requested assistance is not granted by Kashiika Foundation, in part or in full, then the Hospital reserves its right to make up the shortfall from another NGO or any other source. This confirmation essentially states that the Hospital will not avail any financial assistance for the same patient/condition from any other NGO or any other source. (2) The assistance from Kashiika Foundation is only financial in nature. The choice of the treatment/procedure/afforded/collected by the Hospital on the patient is based on the arrangement between the patient & the Hospital, and it is to be understood by Kashiika Foundation. Hence, the Hospital will ensure full & complete responsibility of the treatment & its outcome & safety of the patient, and Kashiika Foundation will have no role or responsibility in the matter. (3) I (Applicant) am aware that any such use of my name, address, photo & details of the "purpose" for which such assistance is requested/planned, will not automatically entitle me for receiving or continuing the said assistance. The decision for granting and/or continuing the assistance will rest solely with the Trustees of Kashiika Foundation and their decision in this regard will be final and acceptable to me. (4) I (Applicant) am aware that any such use of my name, address, photo & details of the "purpose" for which such assistance is requested/planned, will not automatically entitle me for receiving or continuing the said assistance. The decision for granting and/or continuing the assistance will rest solely with the Trustees of Kashiika Foundation and their decision in this regard will be final and acceptable to me. (5) I (Applicant) am aware that any such use of my name, address, photo & details of the "purpose" for which such assistance is requested/planned, will not automatically entitle me for receiving or continuing the said assistance. The decision for granting and/or continuing the assistance will rest solely with the Trustees of Kashiika Foundation and their decision in this regard will be final and acceptable to me.	
RECOMMENDED FOR ACCEPTANCE (पेशेवर डॉक्टर को)	
Date of Surgery (पेशेवर डॉक्टर को) 29/01/25	Dr. CHIRANJIV GUPTA (पेशेवर डॉक्टर को) Assistant and Ocular Oncology Services Regd. No. 122748 Dr. Chiranjiv Gupta Eye Hospital (Name of Dr. & Regd. No. with Stamp) (पेशेवर डॉक्टर को)
FOR INTERNAL USE of KASHIKA FOUNDATION (पेशेवर डॉक्टर को)	
SIGNATURE of TRUSTEE 1 (पेशेवर डॉक्टर को)	SIGNATURE of TRUSTEE 2 (पेशेवर डॉक्टर को)
	



21st January 2025

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital

Please find below attached estimate expenditure of Yug Tripathi- E/0125/0036

Estimate cost of treatment Dr. Shroff's Charity Eye Hospital <u>Retinoblastoma Surgeries</u>					
Name	Yug Tripathi		Address	Village post Akzari, Rasthawali, Uttar Pradesh-220001	
Age	08L-P-25-01-0123		Age/Sex	2 years	Male
S. No.	Treatment date	Item	Cost per unit	No. of unit	Approx. Cost
1	2025-01-26	EUA	2000	1	2000
2	2025-01-31	MRI	6500	1	6500
		Total			8500

Best Regards

Dr. Nima 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 4844, 4352 8888, Fax : 011-43528510
 E-mail : soeh@soeh.net, Website : www.soeh.nal

OTHER CENTRES:

ALWAR • BHARANPUR • MEDHUT • LAKHIMPUR KHURI • SHIBDARAN • KARDIL BAGH (DELHI) • MODI NAGAR • MANDROET