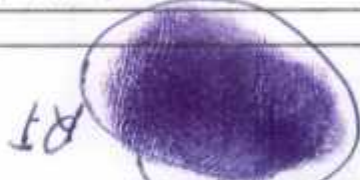
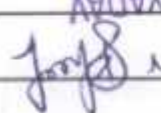


Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशी
	Nil	

DECLARATION by APPLICANT: सहकर्ता गुरु धर्मराज राय 1) I hereby confirm 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 rejection/cancellation. 2) I solemnly confirm that assistance, if received from Koshika Foundation, will be used only for the "purpose", as stated in this Form, for which such assistance was requested by me. 3) I hereby confirm that I have not & will not in future, avail of reimbursement, in part or in full, from any other source/employer/insurance company, of the amount for which this assistance is requested. 4) I do hereby confirm that I have not & will not in future, avail of reimbursement, in part or in full, from any other source/employer/insurance company, of the amount for which this assistance is requested.		AGREEMENT by APPLICANT (सहकर्ता गुरु धर्मराज राय) 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and its Trustees to use/publish/put-up/reproduce my name, address, photo & details of the "purpose", for which such assistance is requested/granted, through any medium, including but not limited to verbal, print, electronic, for soliciting donations for Koshika Foundation and/or disseminating information about its activities/achievements. 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. 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, 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 Koshika Foundation, and their decision in this regard will be final and acceptable to me.		APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION : 		AGREEMENT by HOSPITAL (सहकर्ता गुरु धर्मराज राय) By affixing hereunder, signature of our Authorised Signatory for recommending this case/patient for financial assistance from Koshika Foundation, we (Hospital) hereby affirm & accept 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 patient/case, as we are requesting to get from Koshika Foundation, to the extent that such assistance is granted by Koshika Foundation. If the requested assistance is not granted by Koshika 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 duplicate assistance for the same patient/case from any other NGO or any other source. 2) The assistance from Koshika Foundation is only financial in nature. The choice of the treatment/procedure advised/conducted by the Hospital on the patient, is based 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 & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter. 3) Grant of financial assistance by Koshika Foundation to the patient will be subject to the condition that the patient will not seek any other financial assistance from any other source, for the same patient/case, as we are requesting to get from Koshika Foundation, to the extent that such assistance is granted by Koshika Foundation. If the requested assistance is not granted by Koshika 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 duplicate assistance for the same patient/case from any other NGO or any other source. 4) The Hospital will not avail any duplicate assistance for the same patient/case from any other 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.	
RECOMMENDED FOR ACCEPTANCE सहकर्ता गुरु धर्मराज राय 		Date of Surgery 20/08/25 सहकर्ता गुरु धर्मराज राय		(Name of Dr. & Reg. No.) Dr. Mond, Rameez Reza M.B.B.S. M.S. Ophthalmology Reg. No. 12558 (Stamp) (Name of Dr. & Reg. No.) Dr. Shinde & Co. Hospital (Stamp) (Name of Dr. & Reg. No.) Dr. Shinde & Co. Hospital (Stamp)		FOR INTERNAL USE OF KOSHIKA FOUNDATION सहकर्ता गुरु धर्मराज राय	
SIGNATURE OF TRUSTEE 1 सहकर्ता गुरु धर्मराज राय		SIGNATURE OF TRUSTEE 2 सहकर्ता गुरु धर्मराज राय					