

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)

Koshika
Foundation

Building Block of Life

APPLICATION No.: 6/0717/87 (A669/17) APPLICATION DATE: 15/7/17

NAME of APPLICANT: Satya Prakash AGE-YEARS आनु-वर्ष 68 SEX लिंग M

FATHER'S/SPOUSE'S NAME: late Om Prakash

PRESENT RESIDENCE ADDRESS वर्तमान निवासस्थान पता

602, Sunlight Colony Ashram New Delhi

PERMANENT RESIDENCE ADDRESS स्थायी निवासस्थान पता

Mr. Milano

OCCUPATION: Unemployed

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME: Rs. 1.00 lakh (Family Income) (Attach Proof of Income) -

PAN No. स्थायी खाता संख्या -

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable):
क्या आप आय कर दाता हैं (जो मान्य हो उस पर सही का निशान लगाएं)

Yes (हाँ) / 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	Amal	38	M	Son
2	Satyanvir	35	M	Son

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)
सहायता के लिए विवक्षित आधार

BPL Card (Attach Card Copy) बीपीसी कार्ड के चिप प्रमाण पत्र (प्रमाण पत्र की सहायता प्रिंट संलग्न करें)	EWS Certificate (Attach Certificate Copy) एचएस प्रमाण पत्र प्रमाण पत्र (प्रमाण पत्र की सहायता प्रिंट संलग्न करें)	Ration Card (Attach Copy) उपभोग्यता कार्ड (प्रमाण पत्र की सहायता प्रिंट संलग्न करें)	Any Other Basis/Proof अन्य कोई प्रमाण
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"PURPOSE" for REQUESTING ASSISTANCE:

सहायता हेतु किसे मने निम्न का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अनुसंधान/प्रीस्क्रिप्शन से जारी की गई प्रतिवेदन सूची संलग्न
	Drug:- (20) Cotinect
	Syr:- (20) Flacort-100

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

इस उद्देश्य के हेतु कहीं अन्य सहायता किसी अन्य स्रोत से लिख गइ है?

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED इस हेतु सहायता का

DECLARATION by APPLICANT: **अशोक एन. चव्हाण**

t) 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 rescission/cancellation.

2) I solemnly confirm that assistance, if received from Koshka 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 reimbursements, in part or in full, from any other source/employer/insurance company, of the amount for which this assistance is requested.

1) मैं घोषणा करता हूँ कि इस प्रश्न में दिये गये सभी विषय मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विद्यार्थी अपने सत्य ज्ञान पर धरा के दो मेरी जाणत निरा को न समझती है।

3) मैं सुनिश्चित करता हूँ कि जिस सहकारिता अनुदान प्रक्रिया की मदद से, जहाँ शक्ति का उपयोग या समर्थन दिया किसी अन्य संगठन/व्यक्ति/संस्था/संस्थान के पक्ष में किया जायेगा, मैं इसे पक्ष में हूँ।

AGREEMENT by APPLICANT (अर्जतक ३० नमूना)

1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and it's Trustees to use/publish/post-up/produce 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 it's activities/achievements. Such use of my photo & details can be made by Koshika Foundation before or after my treatment or fulfilment 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.

1) इस उपाय का अगले इस्तेमाल या अंग्रेजों को इसका सामना, मैं (आवेदन) अपनी क्षमता की पूर्ण कक्षा है एवं "बौद्धिक प्रारंभिक और उच्चोत्तरी" को अधिकृत करते हैं कि यह सब, पता, कोई और को विचार इस प्रश्न में रखा है, उसे "बौद्धिक" एवम् न्यायी, मात्र, साधकच दुरुत उत्तरों से मुक्ति नीतिनिर्देश और उपनिर्देशों को उनके विचारों की प्रजात सामान्य।

2) वे (ज्योतिष) इस बात से सम्मत हैं कि मेरा जन्म, पढ़ाई, पोटों और शिवराज जी के भगवानों के दर्शन से ही प्रेरित हो चुका हूँ। शिवराज जी के दर्शन से ही मैंने अपना जीवन "सर्वोत्थान" नामक एक नई राह में चलाने का फैसला किया है।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION

જાણકને જે કમલના યા મંગલે આ વિદ્યા

AGREEMENT by HOSPITAL (इस्पताल द्वारा किया)

By affixing hereunder, signature of our Authorized 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 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 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.

in the matter.

[illegible][illegible]

RECOMMENDED FOR ACCEPTANCE

इन्दीकृतौ च लिप् संस्तुति

Date of Surgery
अवस्था की तारीख

Dr. Shubha Mehta,
DMC No. 64795
(Name of Dr. & Regn. No. with Stamp)
डाक्टर का नाम व हस्ताक्षर व रजि. नं.

Dr. V. S. Thakral
Medical Superintendent
Shri. Durgam Chhaya Camp of Authorized Signatory
A-9, Kailash (opposite of Hospital)
New Delhi-110002
अधिकृत अधिकारी

FOR INTERNAL USE of KOSHIKA FOUNDATION अन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1
नाम: []

SIGNATURE of TRUSTEE 2
न्यासी हस्ताक्षर 2