

APPLICATION FORM FOR ASSISTANCE (Healthcare)		(स्वास्थ्य देखभाल)		
APPLICATION No.: 5/0717/173 (5569/17)		APPLICATION DATE: 24/07/17		
NAME of APPLICANT: PARMESHWAR		AGE-YEARS: 60y	SEX: M	
FATHER'S/SPOUSE'S NAME: Late Ramchand				
PRESENT RESIDENCE ADDRESS: 90A, Zamindapur, New Delhi				
PERMANENT RESIDENCE ADDRESS: As Above				
OCCUPATION: Unemployed		MARRIED (विवाहित) / UNMARRIED (अविवाहित)		
TOTAL ANNUAL INCOME: -		(Attach Proof of Income)		
PAN No. -				
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): Yes (No)				
FAMILY DETAILS				
Sr. No.	Name of Family Member	Age (Years)	Gender	Relation with Applicant
01	Chander Mahale	50	M	Brother - 1st Law
BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)				
BPL Card (Attach Card Copy)	EWS Certificate (Attach Certificate Copy)	Ration Card (Attach Copy)	Any Other Data/Proof	
"PURPOSE" for REQUESTING ASSISTANCE:				
Sr. No.	Medical Reports/Prescriptions Attached			
	Diag:- (LE) Cataract			
	Surv:- (LE) ECCE F10L			
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES				
Sr. No.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED		
	NIL			

DECLARATION by APPLICANT: आर्नेक हुन घोषणा छै:

- 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.
- 1) मैं यहाँ पर कहे हैं कि इस प्रश्न में दिये गये सभी विवरण मेरे जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई मिथ्या एवं झूठ अथवा गलत बात है तो मेरी जानकारी सिद्ध हो जा सकती है।
- 2) मैं इस से सहमत रहित "कौशिका फाउण्डेशन", से जो मदद पा रहा हूँ, उसका उपयोग केवल उद्देश्य के लिए ही करूँगा जिसके लिए मैंने मदद माँगी, जो इस प्रश्न में भरा गया है।
- 3) मैं यहाँ पर कहे हैं कि मैंने अब तक और भविष्य में भी किसी अन्य स्रोत/रोजगार/बीमा कंपनी से मदद के लिए नहीं किया है और नहीं करूँगा।

AGREEMENT by APPLICANT (सापेक्ष पृष्ठ ३-०८)

- 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/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 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 प्रश्न का उत्तर दस्तावेज का अंशों को हटा लगाकर, मैं (आवेदक) अपनी सहमति को पुनः करता हूँ एवं "कोशिका फाउंडेशन और उसके न्यासीयों" को अधिकृत करता हूँ कि मेरा नाम, पता, फोटो और मेरे विषय इस प्रश्न में घोषित है, इसे "कोशिका" द्वारा न्यासी, धर्म, पाबन्धन, धर्म, उद्देश्य से मुझे प्रतिनिधियों और उपस्थितियों को तैयार करने में प्रसारित करने के लिए अधिकृत है।
- 2) मैं (आवेदक) इस बात से सहमत हूँ कि मेरा नाम, पता, फोटो और विषय को निम्नलिखित में प्रसारित से मुझे दस्तावेज का हस्ताक्षर भी करता इस संबंध में "कोशिका" द्वारा उसके न्यासीयों का निर्णय अंतिम और अप्रत्यक्ष होगा।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

आगे के हलाने के अंश के लिए

परमेश्वर

AGREEMENT by HOSPITAL (रखणवाक हस्त करीव)

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 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 & it's outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.

RECOMMENDED FOR ACCEPTENCE

स्वीकृती के लिए संस्तुति

Date of Surgery
ऑपरेशन की गति

17

24/7/13

Dr. Stephen M. Kohn
Executive Director

Name of CE & Regn

संख्या का नाम ११३

इसके अलावा, यह भी ध्यान रखना चाहिए कि

Dr. V.P. Thakral

Medicine/Drug Designation

HROFF EYE CENTER

A-9, Kallash Gallery*

Metric Data: 107.08 S

FOR INTERNAL USE of KOSHIKA FOUNDATION

आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1

संज्ञा रत्नाकरः ।

Signature

SIGNATURE of TRUSTEE 2

व्याप्य इत्युक्ता २

202