

APPLICATION FORM FOR ASSISTANCE
(Healthcare)

(सहायता हेतु आवेदन प्रारूप)

Koshika
foundation
Building Block of life

APPLICATION No.: K/0717/0665 APPLICATION DATE: 25.07.17

NAME of APPLICANT: HANBUR PANNANI AGE-YEARS: 65 SEX: M

FATHER'S/SPOUSE'S NAME: JAYAD MOLLA

PRESENT RESIDENCE ADDRESS: NEDIALA, GORAPAN, JAYANAFAR, Dist - 24 PGS (S) WB INDIA 743391

PERMANENT RESIDENCE ADDRESS: Same as Above

OCCUPATION: K/L

TOTAL ANNUAL INCOME: 24000/-

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
1.	Habibur Rahman Molla	65	M	Self
2.	Torluna Biba	35	F	Wife
3.	Hafiza Khatun	18	F	Daughter
4.	Hafizul Molla	18	M	Son
5.	Katiza Khatun	14	F	Daughter

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

BPL Card (Attach Card Copy)	EWS Certificate (Attach Certificate Copy)	Ration Card (Attach Copy)	Any Other Basis/Proof
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"PURPOSE" for REQUESTING ASSISTANCE:

Medical Reports/Prescriptions Attached

1.	Diagnosis: Glaucoma L/E
2.	Treatment: TRAB + MMC + LA L/E

ASSISTANCE BEING AWAIRED for SAME "PURPOSE" from OTHER SOURCES

Sr. No.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AWAIRED

DECLARATION by APPLICANT: अर्शेक हस घोषण कर:

- 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 घोषणा करता हूँ कि इस प्रत्यक्ष में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण सत्य नहीं बताया गया था या गलत था तो मैं इसे स्वीकार करता हूँ कि मैं गलत हूँ।
- 2) मैं घोषणा करता हूँ कि मैंने "उद्देश्य" के रूप में, जो इस प्रत्यक्ष में बताया गया है, के लिए मदद मांगी है, और मैंने इस मदद का उपयोग केवल उसी उद्देश्य के लिए ही करना है।
- 3) मैं घोषणा करता हूँ कि मैंने इस मदद के लिए या भविष्य में नहीं, इस मदद का उपयोग या भविष्य में किसी अन्य स्रोत/एम्प्लॉयर/इंश्योरेंस कंपनी से न ही किया है और न ही करूँगा।

AGREEMENT by APPLICANT (अर्शेक हस कर)

- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise 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.
- 1) इस प्रत्यक्ष पर मेरी हस्ताक्षर या अंगूठे की छाप लगाकर, मैं (अर्शेक) अर्शेक घोषणा की पुष्टि करता हूँ एवं "उद्देश्य" के रूप में, जो इस प्रत्यक्ष में बताया गया है, के लिए मदद मांगी है, और मैंने इस मदद का उपयोग केवल उसी उद्देश्य के लिए ही करना है।
- 2) मैं (अर्शेक) इस बात से सहमत हूँ कि मेरी हस्ताक्षर या अंगूठे की छाप लगाकर, मैंने इस मदद का उपयोग केवल उसी उद्देश्य के लिए ही करना है, और मैंने इस मदद का उपयोग केवल उसी उद्देश्य के लिए ही करना है।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

अर्शेक की हस्ताक्षर या अंगूठे की छाप



LTI of Patient.

AGREEMENT by HOSPITAL (हॉस्पिटल हस कर)

- 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 full & complete responsibility of the treatment & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.
- हम (हॉस्पिटल) यहाँ पर, हमारे अधिकृत हस्ताक्षर के द्वारा, इस मामले/रोगी के लिए वित्तीय सहायता हेतु सिफारिश की जाती है, कि हम (हॉस्पिटल) निम्न प्रकार से कार्य न कर सकेंगे:
- 1) वह कि न तो हमारे पास और न ही भविष्य में वित्तीय सहायता किसी भी स्रोत से प्राप्त होगी या किसी अन्य स्रोत से प्राप्त होगी, जो कि हमें "उद्देश्य" के लिए मदद मांगी है, और मैंने इस मदद का उपयोग केवल उसी उद्देश्य के लिए ही करना है।
- 2) "उद्देश्य" के लिए मदद मांगी है, और मैंने इस मदद का उपयोग केवल उसी उद्देश्य के लिए ही करना है।

RECOMMENDED FOR ACCEPTANCE

अर्शेक की हस्ताक्षर

Date of Surgery
अर्शेक की तारीख

05.06.18

Dr. N. Maju
Dr. N. Maju

(Name of Dr. & Designation with Stamp)

हस्ताक्षर की तारीख और हस्ताक्षर के साथ

(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital)

हस्ताक्षर की तारीख और हस्ताक्षर के साथ

FOR INTERNAL USE of KOSHIKA FOUNDATIONSIGNATURE of TRUSTEE 1
हस्ताक्षर 1

SIGNATURE of TRUSTEE 2
हस्ताक्षर 2