

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)


Koshika
 foundation
 Building Block of life

APPLICATION No. : NNN/0817/0168

आवेदन संख्या :

APPLICATION DATE : 12/08/2017

आवेदन तिथि

NAME of APPLICANT : UMA MAJI

आवेदक का नाम

AGE-YEARS आयु-वर्ष

72

SEX लिंग

F

FATHER'S/SPOUSE'S NAME : NABAKUMAR MAJI (HUSBAND)

पिता/पति का नाम

PRESENT RESIDENCE ADDRESS : वर्तमान आवासीय पता

VILL - CHAKPUT : P.O. - AMTA : P.S. - AMTA.

DIST - HOWRAH : जिला -

PERMANENT RESIDENCE ADDRESS : स्थायी आवासीय पता

Do.



PREOP

POSTOP

0168

UMA

OCCUPATION : HOUSE WIFE

व्यवसाय

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME : 20,000 ₹ (YEARLY)

कुल वार्षिक आय

(Attach Proof of Income)
(आय का सबूत संलग्न करें)

PAN No. : 3445 3445 3445

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

Yes / No

हां / 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 से संबंध
1.	NABAKUMAR MAJI	80	M	HUSBAND
2.	AKMAL MAJI	50	M	SON
3.	SHYAMAL MAJI	45	M	SON
4.	SHUMPA MAJI	35	F	SON-IN-LAW
5.	ANURAG MAJI	14	M	GRAND CHILD
6.	ANURAG MAJI	8	F	GRAND CHILD

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)
सहायता के निम्न विधि आधार

BPL Card (Attach Card Copy) गरीबी रेशा के नीचे प्रमाण पत्र (प्रमाण पत्र की प्रतिलिपि संलग्न करें)	EWS Certificate (Attach Certificate Copy) आय आय वर्ग प्रमाण पत्र (प्रमाण पत्र की प्रतिलिपि संलग्न करें)	Ration Card (Attach Copy) रेशियन कार्ड (प्रमाण पत्र की प्रतिलिपि संलग्न करें)	Any Other Basis/Proof अन्य कोई सबूत
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"PURPOSE" for REQUESTING ASSISTANCE:

सहायता हेतु किये गये निम्न का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रिविशन सूची संलग्न
1.	DIAGNOSIS - RE-NUCLEAR SCLEROSIS, TITR
2.	SURGERY - SLES WITH PERIOL

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य को हेतु कोई अन्य सहायता किसी अन्य स्रोत से प्राप्त गयी है?

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशि
	V. M. A. N. N. N.	

DECLARATION by APPLICANT: जलेश्वर दत्त शर्मा वगैरे

- 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) ये शक्यता बताते हैं कि इस प्रमाण से दिये गये सभी विवरण सही जानकारी को अनुरोध प्राप्त एवं सही है। यदि कोई विवरण एवं प्रमाण अलग प्राप्त होता है तो सही जानकारी प्राप्त की जा सकती है।
- 2) ये इस को सत्यापन प्रति "अतिरिक्त प्रमाणपत्र", से भी जा सही है, जिसका उपयोग सभी सदस्यों को पूर्ण से मिले बिना उपयोग, को इस प्रमाण में प्राप्त नहीं है।
- 3) ये शक्यता बताते हैं कि जिस सत्यापन से यह प्रमाण को सही है, उस प्रति का अतिरिक्त या अलग विवरण किसी अन्य प्रमाणपत्र/प्रमाणपत्र प्रमाणों से न मिले है और न ही अतिरिक्त में नहीं।

AGREEMENT by APPLICANT (signw. and init.)

- 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.

- [illegible]

- 2) मैं (अवस्था) इस बात से सज्जत हूँ कि वेद नव, पण, पाठों और विभागों में कि साधना में उत्पत्ति में हुई है। साधना का प्रकार भी बताया है। इस प्रसंग में "अवस्था" शब्द उसके व्युत्पत्ति का विशेष अर्थ और समझाया होगा।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

AGREEMENT by HOSPITAL: (REFUSE OR WITH)

By affixing hereunder, signature of our Authorized Signatory for recommending this candidate 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 declaration constitutes a pledge 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.

- उदा० प्रथिबुस, हजाराधी की ओर से यमलेगीरी को "भोलिका चारुन्देव" से विविध सहायक हेतु शिवांगि की जाती है, जिसे उ० (हजाराध) निम्न प्रकार से मान्य व उद्देश्य करते हैं।

- [illegible]

- [illegible]

RECOMMENDED FOR ACCEPTENCE

सभीकृती के लिए संभारित

Date of Surgery
ऑपरेशन की तारीख

24/08/17

DR. A. V.

MEDICAL OFFICER
NETRA KIRANAY NIKETAN
WIPAKHANTA JERISON AGRAM
(Name of Dr. & Regn. No. with Stamp)

49490/
09/04/2000

6th Sy. DY MANAGER
VMA NETRA NIRAMAY NIKETAN
PLOT 2 BAITANYA PURI, HALDOL
DIST. PURBA MEDINIPUR
(near of Hospital)
2000 sq. ft. approx. surface
authorised Signatory

FOR INTERNAL USE of KOSHIKA FOUNDATION

आभारिक कर्मचारी हे

SIGNATURE of TRUSTEE 1

ज्यामी हास्याक्षी ।

Exempel

SIGNATURE of TRUSTEE 2

म्यामी समुदाय I

per