

APPLICATION FORM FOR ASSISTANCE (Healthcare)		(स्वास्थ्य देखभाल)		
APPLICATION No.: 5/09/238 (09/17)		APPLICATION DATE: 12/9/17		
NAME of APPLICANT: Pata Devi		AGE-YEARS आयु-वर्ष: 40y		
FATHER'S/SPOUSE'S NAME: Lt. Chittan Das		SEX लिंग: F		
PRESENT RESIDENCE ADDRESS: H-11, 234, 1st Gudio Comp, Sumitpur N.D.				
PERMANENT RESIDENCE ADDRESS: As Above				
OCCUPATION: housewife		MARRIED (विवाहित) / UNMARRIED (अविवाहित)		
TOTAL ANNUAL INCOME: Rs 70,000/- (Family Income)		(Attach Proof of Income)		
PAN No. रण्ड खाता संख्या: -				
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): Yes (No)				
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 सम्बंध
1	Raj Kumar	43	M	Son
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	
"PURPOSE" for REQUESTING ASSISTANCE:				
Medical Reports/Prescriptions Attached				
Diag:- LE Cataract				
Tx:- (Rx) Phaco+IOL				
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES				
Sr. No. क्रम संख्या	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED		
Total				

DECLARATION by APPLICANT: અર્થદાતા દ્વારા ઘોષણા પત્ર:

- 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 प्रारूप में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण एवं/वाचन असत्य पाया जाता है तो मेरी सहायता निरस्त की जा सकती है।
- 2) मेरी दृढ़ता है सहायता का उपयोग केवल "उद्देश्य" के लिए ही किया जायेगा, जो इस प्रारूप में पता चला है।
- 3) मैं पुनः प्रमाणित करता हूँ कि मैं किसी सहायता से न लाभ उठाऊंगा और भविष्य में भी नहीं करूंगा, जिससे मैं किसी अन्य स्रोत/रोजगार/बीमा कम्पनी से न तो हिसा है और न ही क्षतिपूर्ति प्राप्त कर सकूँ।

AGREEMENT by APPLICANT (अनुमतिद्वारा आवेदक)

- 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/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 it's 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:

आगे बढ़ते हैं तो हमें यह भी ध्यान रखना पड़ेगा कि

(Pala Devi)

AGREEMENT by HOSPITAL (हस्पताल द्वारा मंजूर)

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

RECOMMENDED FOR ACCEPTENCE

स्त्रीकृती के लिए संस्कृति

Date of Surgery
अपरेशन की तारीख

Dr. Shubha Mehta
(Name of Dr. & Regn. No. with Stamp)
DMC No. 64738
डाक्टर का नाम व हस्ताक्षर व सील नं.

Dr. V.P. Thakral
Medical Director and Stamp of Authorised Signatory
SHROFF EYE HOSPITAL (Central Hospital)
A-9, Kirti Khera, Gurgaon
New Delhi-110 046

FOR INTERNAL USE of KOSHIKA FOUNDATION

आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1
रमणी इस्ताख़ 1

SIGNATURE of TRUSTEE 2
न्यासी इन्साफर 2