

## APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)

Koshika  
foundation

Building block of life.

APPLICATION No. :

आवेदन संख्या :

K/0118/1727

APPLICATION DATE :

आवेदन तिथि

09/01/18

NAME of APPLICANT :

आवेदक का नाम

JOGENDRA SARKAR

AGE-YEARS आयु-वर्ष

SEX लिंग

76

M

FATHER'S/SPOUSE'S NAME :

पिता/पत्नी का नाम

PRAHLAD SARKAR

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

PART NO-215, DUMDUM MUNICIPALITY, JESSORE  
RDP NORTH 24 PARGANAS, WEST-BENGAL

PERMANENT RESIDENCE ADDRESS : स्थाई आवासीय पता

AS ABOVE

OCCUPATION :

व्यवसाय

UNEMPLOYED

TOTAL ANNUAL INCOME :

कुल वार्षिक आय

NIL

(Attach Proof of Income)

(आप का साक्ष्य संलग्न)

PAN No. स्थाई 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 / No

हां / नहीं

## FAMILY DETAILS परिवार विवरण

| Sr. No.<br>क्रम संख्या | Name of Family Member<br>परिवार के सदस्यों का नाम | Age (Years)<br>उम्र (वर्ष) | Gender<br>लिंग | Relation with Applicant<br>आवेदक के साथ सम्बंध |
|------------------------|---------------------------------------------------|----------------------------|----------------|------------------------------------------------|
| 1.                     | JOGENDRA SARKAR                                   | 76                         | M              | SELF                                           |
| 2.                     | BIVA SARKAR                                       | 66                         | F              | WIFE                                           |
| 3.                     | PAMELA SARKAR                                     | 40                         | F              | DAUGHTER                                       |
| 4.                     | JAYANTI SARKAR                                    | 25                         | F              | DAUGHTER                                       |

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

सहायता के लिये विनति आधार

|                                                                                                                   |                                                                                                                   |                                                                                           |                                              |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|----------------------------------------------|
| BPL Card<br>(Attach Card Copy)<br>गरीबी रेशन कार्ड के नौबे प्रमाण पत्र<br>(प्रमाण पत्र की छाया प्रति संलग्न करें) | EWS Certificate<br>(Attach Certificate Copy)<br>आय आय वर्ग प्रमाण पत्र<br>(प्रमाण पत्र की छाया प्रति संलग्न करें) | Ration Card<br>(Attach Copy)<br>उपभोक्ता कार्ड<br>(प्रमाण पत्र की छाया प्रति संलग्न करें) | Any Other<br>Basis/Proof<br>अन्य कोई साक्ष्य |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|----------------------------------------------|

"PURPOSE" for REQUESTING ASSISTANCE:

सहायता हेतु किये गये निम्नी का उद्देश्य:

| Sr. No.<br>क्रम संख्या | Medical Reports/Prescriptions Attached<br>अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न |
|------------------------|----------------------------------------------------------------------------------------------|
| 1.                     | DIAGNOSIS - CATARACT - LE                                                                    |
| 2.                     | SURGERY - LE (GOS + IOL)                                                                     |

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिया गया हो?

| Sr. No.<br>क्रम संख्या | NAME of OTHER SOURCE<br>अन्य स्रोत का नाम | AMOUNT of ASSISTANCE BEING AVAILED<br>ली गई सहायता राशी |
|------------------------|-------------------------------------------|---------------------------------------------------------|
|                        |                                           |                                                         |
|                        |                                           |                                                         |
|                        |                                           |                                                         |

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, if the amount for which this assistance is requested).

- 1) मैं सोचता हूँ कि इस प्रश्न में रिश्वत को सभी विभागों में समुदाय स्तर पर लाना है। यदि कोई विभाग एक अलग अलग स्तर पर है तो सभी स्तरों पर रिश्वत को लाना पड़ेगा।
- 2) मैं इस पर साफ़ तौर पर "नो" कह रहा हूँ, क्योंकि हमारे सभी लोगों को पुराने के रिश्वत विभाग में लाना पड़ेगा। यह इस प्रश्न में नहीं है।
- 3) मैं पुष्टि करता हूँ कि जिस साफ़ तौर पर प्रश्न को मैं हूँ, उस तौर पर अधिकार का समान विभाग किसी अन्य व्यक्ति/विभाग में नहीं आया है। मैं इसे हूँ और मैं इसे हूँ।

1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Kishika Foundation and it's Trustees to use/publish/post-upreproduce 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 to Kishika Foundation and/or disseminating information about it's activities/achievements. Such use of my photo & details can be made by Kishika 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, 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]

आवेक भे इलाका या अंग्रे के निगम

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. The 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.

हमारे अधिवक्ता, राजस्थान की ओर से गुजरात/देहली को "कॉन्सिडरेशन" से विविध मांगों से विचारित की जाती है, किंग टन (हथियार)। एक लाख से कम में अधिक नहीं।

- [illegible]

- [illegible]

संस्तुति (स्वीकृत/निरस्त का निशान लगावे)

## 374

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09/01/18

Dr. Arindam Deb  
MBBS, DO, FRCS  
Reg. No. 58096  
Sri Sri Eye Foundation & Research Centre  
(Name of Dr. & Regn. No. with Stamp)  
डाक्टर का नाम व इलाका बरिद न

*(Signature)* Sanjay Bagchi  
 Director  
 Sankalpa Eye Foundation & Research Centre  
 (Name, Designation & Stamp of Authorized Signatory  
 on behalf of Hospital)  
 सन व. पा. हस्पताल अधिकारी, अहमदाबाद

## FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु

|                         |                    |                                                                                     |                                                                                       |
|-------------------------|--------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| SANCTIONED<br>सन्तुष्टि | REJECTED<br>समन्वय | SIGNATURE of TRUSTEE 1<br>नामो इनामदार 1                                            | SIGNATURE of TRUSTEE 2<br>नामो इनामदार 2                                              |
|                         |                    |  |  |