

DECLARATION by APPLICANT (अप्लिकेंट द्वारा कराया जाना):

- 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.
- 4) I have read & understood the terms & conditions of Koshika Foundation & accept them fully & without any reservations. I also understand that I will be liable to Koshika Foundation for the amount of assistance received if I avail of reimbursement from any other source/employer/insurance company.
- 5) I declare that I am not receiving any financial support from any other organization.
- 6) I declare that I am not receiving any financial support from any other organization.
- 7) I declare that I am not receiving any financial support from any other organization.

AGREEMENT by APPLICANT (अप्लिकेंट द्वारा कराया जाना):

- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize 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.
- 3) I declare that I am not receiving any financial support from any other organization, as "Koshika Foundation" has not granted any financial support to me, and I do not receive any financial support from any other organization.
- 4) I declare that I am not receiving any financial support from any other organization, as "Koshika Foundation" has not granted any financial support to me, and I do not receive any financial support from any other organization.
- 5) I declare that I am not receiving any financial support from any other organization, as "Koshika Foundation" has not granted any financial support to me, and I do not receive any financial support from any other organization.

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

अप्लिकेंट द्वारा कराया जाना जितना



AGREEMENT by HOSPITAL (हॉस्पिटल द्वारा कराया जाना):

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 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 sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.
- 3) यदि अधिकारी, अस्पताल की ओर से आवश्यकता की "कोशिका प्राप्तिकरण" द्वारा सहायता दी जाती है, तो हम (अस्पताल) निम्न चर्चा में जानकारी देंगे हैं।
- 4) हम निम्न में वर्णित हैं कि कोशिका प्राप्तिकरण की सहायता दी जानी वाली अस्पताल को निम्न चर्चा में दी गई है। यदि हम इसी "कोशिका प्राप्तिकरण" में विवरित/विवरित तरह में सहायता दी जाना वाली "कोशिका प्राप्तिकरण" द्वारा सहायता दी जानी वाली निम्न चर्चा में दी जाना वाली निम्न चर्चा में सहायता दी जानी वाली अस्पताल में सहायता दी जानी वाली अस्पताल को निम्न चर्चा में दी जानी वाली अस्पताल है। इस दृष्टि से जानकारी दी जानी वाली अस्पताल है।
- 5) "कोशिका प्राप्तिकरण" द्वारा दी जानी वाली निम्न चर्चा में दी जानी वाली अस्पताल में सहायता दी जानी वाली अस्पताल है। यदि निम्न चर्चा में दी जानी वाली अस्पताल को निम्न चर्चा में दी जानी वाली अस्पताल है, तो "कोशिका प्राप्तिकरण" द्वारा सहायता दी जानी वाली अस्पताल है।
- 6) "कोशिका प्राप्तिकरण" द्वारा दी जानी वाली निम्न चर्चा में दी जानी वाली अस्पताल है। यदि निम्न चर्चा में दी जानी वाली अस्पताल को निम्न चर्चा में दी जानी वाली अस्पताल है, तो "कोशिका प्राप्तिकरण" द्वारा सहायता दी जानी वाली अस्पताल है।

**RECOMMENDED FOR ACCEPTANCE
अस्पताल की विषय संक्षेपी**

Date of Surgery अस्पताल की ओर 10/12/18	Dr. K. Ghosh MBBS, DO, DNB, FRCS (Name of Dr. & M.A./M.B.B.S. With Stamps) Sushil Kumar Ghosh M.B.B.S. with Stamps	Sushil Sankar Bagchi Director (Name, Designation & Stamp of Authorized Signatory on behalf of Hospital) एस. ए. बैग्ची डिप्लोमेट अस्पताल
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FOR INTERNAL USE of KOSHICA FOUNDATION

अस्पताल द्वारा

SIGNATURE of TRUSTEE 1 नियमित अधिकारी 1 	SIGNATURE of TRUSTEE 2 नियमित अधिकारी 2
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