

APPLICATION FORM FOR ASSISTANCE सहायता हेतु आवेदन प्रारूप		(Healthcare) (स्वास्थ्य देखभाल)		 Koshika foundation Building Blocks of Life.	
APPLICATION No. : K/128/1872		APPLICATION DATE : 11/12/18			
NAME of APPLICANT : ANJALI SINGH		AGE-YEARS 60	SEX F		
FATHER'S/SPOUSE'S NAME : BINDA SINGH				 	
PRESENT RESIDENCE ADDRESS 80 SURAN SARKAR ROAD, WEST KOLKATA					
PERMANENT RESIDENCE ADDRESS : AS ABOVE					
OCCUPATION : HOUSE WIFE					
TOTAL ANNUAL INCOME : NIL		(Attach Proof of Income)			
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.	ANJALI SINGH	60	F	SELF	
2.	BINDA SINGH	71	M	HUSBAND	
3.	SHRUTI SINGH	56	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					
Sr. No.	Medical Reports/Prescriptions Attached				
1.	DIAGNOSIS - CATARACT - RE.				
2.	SURGERY - RE (Cataract + Tot)				
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES					
Sr. No.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED			

DECLARATION by APPLICANT: (अर्शक द्वारा घोषणा करें)

- 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.
- 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.
- 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.
- मैं घोषणा करता हूँ कि इस प्रकरण में दिये गये सभी विवरण सही जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण सत्य नहीं माना जाय तो उसे ग्राहकता प्राप्त हो ना सकती है।
- मैं इस बात को गारंटी करता हूँ कि "कोशिका फाउंडेशन", से जो भी मदद मिलेगी, उसका उपयोग केवल उद्देश्य के लिए किया जाएगा, जो इस प्रकरण में मांग किया गया है।
- मैं पुष्टि करता हूँ कि मैं इस सहायता हेतु या भविष्य में पूर्णतः, या आंशिक रूप से किसी भी अन्य स्रोत/रोजगार/बीमा कंपनी से न ले सकूँ।

AGREEMENT by APPLICANT (अर्शक द्वारा सहमति)

- By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and its Trustees to use/publish/post-up/produce 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.
- 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.
- इस प्रकरण में मेरी सहमति या स्वीकृति के बिना, मैं (अर्शक) अपनी छवि को प्रयोग करूँगा कि "कोशिका फाउंडेशन और उसके भरोसे" को संचारित करता हूँ कि मेरा नाम, पता, फोटो और मेरे विवरण इस प्रकरण में संचारित हैं, उसे "कोशिका" द्वारा प्रचारित, प्रसारित, प्रकाशित, प्रसारण के माध्यम से प्रसारित करने के लिए किसी भी प्रकार का प्रयास करने के लिए अधिकृत है। मेरी सहमति या स्वीकृति के बिना या बाद में मेरे बिना "कोशिका फाउंडेशन" से सहायता नहीं मिलेगी।
- मैं (अर्शक) इस बात से सहमत हूँ कि मेरा नाम, पता, फोटो और विवरण को बिना सहायता के उपयोग के प्रसारित करने के लिए प्रयोग करने के लिए "कोशिका" द्वारा प्रचारित, प्रसारित, प्रकाशित, प्रसारण के माध्यम से प्रसारित करने के लिए अधिकृत है।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

अर्शक की हस्ताक्षर या बायाँ अंगुली का छाप

AGREEMENT by HOSPITAL (हॉस्पिटल द्वारा सहमति)

- 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:
- 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.
 - 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.
- हमारी स्वीकृति, इस प्रकार की है कि हम "कोशिका फाउंडेशन" से वित्तीय सहायता हेतु सिफारिश कर रहे हैं, बिना हम (हॉस्पिटल) के बिना सहायता के बिना या अन्य स्रोतों से।
- यह कि मैं या मेरी स्वीकृति और न ही भविष्य में वित्तीय सहायता किसी भी सहायता के बिना या अन्य स्रोतों से ले सकूँ, जो कि हमने "कोशिका फाउंडेशन" से सिफारिश/सहायता के बिना या अन्य स्रोतों से ले सकूँ।
 - "कोशिका फाउंडेशन" से जो भी सहायता मिलेगी, उसका उपयोग केवल उद्देश्य के लिए किया जाएगा, जो इस प्रकरण में मांग किया गया है।

RECOMMENDED FOR ACCEPTANCE

स्वीकृति के लिए अनुमति

Date of Surgery अर्शक की तारीख 11/12/18	Dr. K. Chandra MSBS, DO, DNB, FRCS Reg. No. 30971 (Name of Dr. & Regn. No. with Stamp) हस्ताक्षर का नाम व इलाका व पता	Shri Sankar Bagchi (Name, Designation & Stamp of Authorized Signatory) हस्ताक्षर का नाम व इलाका व पता
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FOR INTERNAL USE of KOSHIKA FOUNDATION (आन्तरिक उपयोग हेतु)

SIGNATURE of TRUSTEE 1 आशी इलाका 1	SIGNATURE of TRUSTEE 2 आशी इलाका 2