

APPLICATION FORM FOR ASSISTANCE सहायता हेतु आवेदन प्रारूप		(Healthcare) (स्वास्थ्य देखभाल)		 Koshika foundation Building Block of life	
APPLICATION No.: K/1218/1958		APPLICATION DATE: 12/10/18			
NAME of APPLICANT: SUBOSH KUNAR ROY		AGE-YEARS 30	SEX M		
FATHER/SPOUSE'S NAME: JATINDRAWATH ROY					
PRESENT RESIDENCE ADDRESS: DAKHINMALL DATOLIA KARTAK NIKETH 20 PARAGANES STADIUM, WEST BENGAL					
PERMANENT RESIDENCE ADDRESS: AS ABOVE					
OCCUPATION: UNEMPLOYED		MARRIED (विवाहित) / UNMARRIED (अविवाहित) ☒ ☐			
TOTAL ANNUAL INCOME: NIL		(Attach Proof of Income) (आप का आय प्रमाण)			
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता हैं (को सत्य हो उस पर चिह्न लगा दें)					
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 सम्बन्ध	
1.	SUBOSH KUNAR ROY	30	M	SELF	
2.	PRANASHI ROY	28	F	WIFE	
3.	PRANASHI ROY	25	F	DAUGHTER	
4.	JATINDRAWATH ROY	30	M	FATHER	
BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable) सहायता के लिये निम्न आधार					
BPL Card (Attach Card Copy) गरीबी रेशा के साथ प्रमाण पत्र (प्रमाण पत्र की साथ ही संलग्न करें)		EWS Certificate (Attach Certificate Copy) अल्प आय वर्ग प्रमाण पत्र (प्रमाण पत्र की साथ ही संलग्न करें)		Ration Card (Attach Copy) उपभोग्य कार्ड (प्रमाण पत्र की साथ ही संलग्न करें)	
Any Other Basis/Proof अन्य कोई आधार					
"PURPOSE" for REQUESTING ASSISTANCE: सहायता हेतु किसे लगे निम्न आधार					
Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached मापदण्ड/दवाखत ले जाते हैं या नहीं प्रमाणित सूची संलग्न				
1.	DIAGNOSIS - CATARACT - RE.				
2.	SURGERY - RE (Glas not)				
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिया गया है?					
Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम		AMOUNT of ASSISTANCE BEING AVAILED ले गई सहायता राशि		

DECLARATION by APPLICANT: none yet none yet

- 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 यकीन करता हूँ कि इस प्रश्न में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण सत्य प्रमाण प्रदायक नहीं है तो मेरी प्रार्थना सिर्फ़ की जा सकती है।
- 2) मैं इस बात का आग्रह पूर्ण "कीटिका फाउन्डेशन", से हो जा रही है, प्रस्तावित प्रदान की गई राशि को केवल दिये गए उद्देश्य, जो इस प्रश्न में पता चला है।
- 3) मैं यकीन करता हूँ कि मैं इस प्रदान हेतु या प्रदान की नहीं है, या नहीं या कहीं या प्रदान किया किसी अन्य स्रोत/एम्प्लॉयर/इन्सुरेंस कंपनी से या से लिया है और न ही भविष्य में होगा।

AGREEMENT by APPLICANT (attach one copy)

- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and it's Trustees to use/publish/post/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.
- 1) इस प्रश्न का जवाब इसका या नहीं का कर सकते हैं, मैं (अर्क्षक) अपने पता की पुष्टि करता हूँ कि "कोशिका फाउंडेशन और उसके ट्रस्टियों" को अधिकृत करता हूँ कि वे मेरा नाम, पता, फोटो और मेरे विवरण इस तरह से प्रकाशित करें, जैसे "कोशिका" दूरदर्शन, पत्र, पत्रिकाएं, दूरदर्शन से सुनी रेडियो/टेलीविजन और दूरदर्शनों के लिए किसी भी तरह के माध्यम से प्रकाशित करने के लिए अधिकृत हैं। वे इस का विवरण की इसका मेरे पता का कर के करने के लिए "कोशिका फाउंडेशन" के ट्रस्टियों अधिकृत हैं।
- 2) मैं (अर्क्षक) इस बात से सहमत हूँ कि वे मेरा नाम, पता, फोटो और विवरण को कि प्रकाशित के दूरदर्शनों से प्रकाशित हूँ प्रश्न: प्रकाशित का इच्छा नहीं करता। इस संबंध में "कोशिका" दूरदर्शन ट्रस्टियों का निर्णय अंतिम और अप्रत्यक्ष होगा।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

संदेश में वास्तव में संक्षेप का प्रभाव



AGREEMENT by HOSPITAL (REFUSE OR NOT)

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.

RECOMMENDED FOR ACCEPTANCE

कम्प्यूटरी के लिए संयुक्ति

Date of Surgery 12/12/18	Dr. Shanker Nag (Name of Dr. & Regn. No. with stamp) Research Centre	Shub Sankar Bagchi (Name, Designation & Stamp of Authorised Signatory) Secy to the Director of Hospital	FOR INTERNAL USE of KOSHIKA FOUNDATION
SIGNATURE of TRUSTEE 1 [Signature]	SIGNATURE of TRUSTEE 2 [Signature]		