

APPLICATION FORM FOR ASSISTANCE (Healthcare)		(सहायता हेतु आवेदन प्रारूप)		(स्वास्थ्य देखभाल)	
APPLICATION No. : K/120/2969		APPLICATION DATE : 2/1/2020			
NAME of APPLICANT : JYOTOPAL KUNDU		AGE-YEARS : 70		SEX : M	
FATHER/SPOUSE'S NAME : JITENDRANATH KUNDU					
PRESENT RESIDENCE ADDRESS : 182/4 SUNDIYA PARA, SATYAJEET PALY, KANKRINHA BHATPARA, NORTH 24 PARGANAS 743126, WEST BENGAL					
PERMANENT RESIDENCE ADDRESS : AS ABOVE					
OCCUPATION : UNEMPLOYED			MARRIED (विवाहित) / UNMARRIED (अविवाहित)		
TOTAL ANNUAL INCOME : RS 1600 X 12 = 19200			(Attach Proof of Income)		
PAN No. : [Blank]					
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.	JYOTOPAL KUNDU	70	M	SELF	
2.	KAMAL KUNDU	37	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		Any Other Basis/Proof		Any Other Basis/Proof	
"PURPOSE" for REQUESTING ASSISTANCE:					
Sr. No.	Medical Reports/Prescriptions Attached				
1.	DIAGNOSIS - CATARACT - RE				
2.	SURGERY - RE (STEST 101)				
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES					
Sr. No.	NAME of OTHER SOURCE		AMOUNT of ASSISTANCE BEING AVAILED		

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DECLARATION by APPLICANT: सत्यमेव जयते

- 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 यहाँ पर कड़ा है कि इस प्रत्यय में दिये गये सभी विवरण मेरे व्यक्तिगत के अनुसार सत्य एवं सही हैं। यदि कोई विवरण एवं कथन असत्य पाया जाता है तो मेरी सहायता शिरो भी का सकती है।
- 2) मैं यहाँ पर कड़ा है कि "कीटिका फाउंडेशन", से जो भी मदद मिले, उसका उपयोग इसी उद्देश्य की पूर्ति के लिये किया जायेगा, जो इस प्रत्यय में कहा गया है।
- 3) मैं यहाँ पर कड़ा है कि मैंने भविष्य में इस मदद का पूरा पूरा उपयोग किसी अन्य स्रोत/रोजगार/बीमा कम्पनी से न तो लिया है और न ही भविष्य में लूँगा।

AGREEMENT by APPLICANT (স্বাক্ষর করুন)

- 1) 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/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.
- 1) इस प्रश्न या अपने हस्ताक्षर या अंगूठी की छाप लगाकर, मैं (अर्पितक) अपने छात्रों को पुष्टि करता हूँ कि "कोशिका फाउंडेशन और उसके न्यासीयों" को अधिकृत बना है कि वे मेरा नाम, पता, फोटो और जो विवरण इस प्रश्न में घोषित है, उसे "कोशिका" द्वारा मीडिया, दूर, माध्यम से दूरस्थ से मुझे सौंपे जाने वाले छात्रों के लिए प्रसारित करने के लिए उपयोग करेगा। यह प्रश्न का निष्कर्ष यह होगा कि मैंने या वह मेरे करने के लिए "कोशिका फाउंडेशन" से न्यासी अधिकृत है।
- 2) मैं (अर्पितक) इस बात से सहमत हूँ कि वे मेरा नाम, पता, फोटो और विवरण को बिना किसी भी प्रकार के प्रतिफल के प्रदान करने के लिए उपयोग करेगा। इसका निर्णय केवल ही होगा। इस संबंध में "कोशिका" द्वारा दत्त न्यासीयों का निर्णय अंतिम और स्वीकार्य होगा।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION
 સહાયક ને સ્ટામ્પ ને અંગે નો સ્ટામ્પ



AGREEMENT by HOSPITAL (हस्पताल द्वारा स्वीकृति)

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 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.

हमारे अतिथि, ब्राह्मणों की ओर से स्वागतार्थों को "कलित्वा ब्राह्मणेभ्यः" से विनिवृत्त राखाया हेतु पिछलीस की खरी है, जिसे हम (हमसात) निम्न प्रकार से मान्य व इतीक्य करते हैं।

- [illegible]

2. "कॉलेजियल प्रबन्धन" के दो नए आयामों को ध्यान में रखते हुए, राष्ट्रीय कॉलेजियल प्रबन्धन परिषद (NCP) के अध्यक्ष और सदस्यों को निर्देशित किया गया है कि वे अपने-अपने क्षेत्रों में कॉलेजियल प्रबन्धन के विकास के लिए आवश्यक कदम उठाएं।

RECOMMENDED FOR ACCEPTANCE

स्वीकृति के लिए संकल्पित

Date of Surgery ऑपरेशन की तारीख 21/1/2020	Dr. Priyansha Chatterjee MBBS, DNB Reg. No. - 70555 (Name of Dr. & Regn. No. with Stamp) डॉक्टर का नाम व इलाका व छपाई	Dr. Sangeeta Bagchi (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद इत्यागत अधिकृत अधिकारी
FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु		
SIGNATURE of TRUSTEE 1 न्यायी हस्ताक्षर 1 	SIGNATURE of TRUSTEE 2 न्यायी हस्ताक्षर 2 	