APPLICATION FORM FOR ASSISTANCE
सहायता हेतु आवेदन प्रारूप

(Healthcare)
(स्वास्थ्य देखभाल)

Koshika
foundation
Building block of life

APPLICATION No. / आवेदन संख्या: K/0325/2052

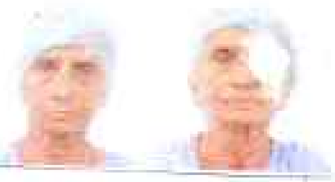
APPLICATION DATE / आवेदन तिथि: 01/03/25

NAME of APPLICANT / आवेदक का नाम: BIDYUT ROY

AGE YEARS / आयु वर्ष: 73

SEX / लिंग: F

FATHER'S/SPOUSE'S NAME / पिता/पति का नाम: GOBINDA ROY



PRESENT RESIDENCE ADDRESS / वर्तमान आवासीय पता

INDIRA NAGAR, BLOCK-3, PANIHATI,
NORTH 24 PARAGANAS, 700115, WEST BENGAL

PERMANENT RESIDENCE ADDRESS / स्थाई आवासीय पता

OCCUPATION / व्यवसाय: COOK

[✓ MARRIED (विवाहित)] / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME / कुल वार्षिक आय: 3500X12 = 42,000/-

(Attach Proof of Income)
(आय का प्रमाण संलग्न)

PAN No. / स्थाई खाता संख्या:

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable):
Yes / [✓ No]
हाँ / नहीं

FAMILY DETAILS / परिवार विवरण

Sr. No. क्र. संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) आयु (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ संबंध
1.	BIDYUT ROY	73	F	SELF
2.	BEAUTY SAHA	50	F	DAUGHTER
3.	BISWANATH ROY	47	M	SON
4.	TUTUL ROY	45	M	SON

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)
सहायता के लिये विशेष आधार

BPL Card (Attach Card Copy)	EWS Certificate (Attach Certificate Copy)	Ration Card (Attach Copy)	Any Other Basis/Proof

"PURPOSE" for REQUESTING ASSISTANCE

Sr. No. क्र. संख्या	Medical Reports/Prescriptions Attached
①	DIAGNOSIS - CATARACT - LE
②	SURGERY - LE (SICS + IOL)

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

Sr. No. क्र. संख्या	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED

DECLARATION by APPLICANT [illegible]

1) I hereby confirm that all details in this Form are true to the best of my knowledge. Any false statement [illegible] 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) [illegible]

2) [illegible] "कोशिका फाउंडेशन" [illegible]

3) [illegible]

AGREEMENT by APPLICANT [illegible]

1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and it's Trustees to use/publish/put-up/reproduce my name, address, photo & details of the "purpose", for which [illegible] 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 fulfilment of the "purpose" for which assistance is being requested.

2) I (Applicant) further agree that any such use of my name, address, photo & details [illegible] for which such assistance is requested/granted will [illegible] entitle me for receiving or continuing the said assistance. The decision [illegible] continuing the assistance will rest solely with the Trustees of Koshika Foundation, and their decision in this regard will be final and [illegible]

1) [illegible] "कोशिका" [illegible]

2) मैं (आवेदक) [illegible]

"कोशिका" [illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :
आवेदक के हस्ताक्षर या अंगूठे का निशान

AGREEMENT by HOSPITAL [illegible]

By affixing hereunder, signature of our Authorised Signatory for recommending this case [illegible] 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 [illegible] 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 [illegible] another NGO or any other source. This [illegible] states that the Hospital will not avail any duplicate assistance for the same [illegible] from any other NGO or any other source.

2) The assistance from Koshika Foundation is only financial in nature. The choice of the [illegible] patient is based on the arrangement between the patient & the Hospital, and [illegible] 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 this matter.

[illegible] "कोशिका फाउंडेशन" [illegible]

1) [illegible]

[illegible] "कोशिका फाउंडेशन" [illegible] "कोशिका फाउंडेशन" [illegible]

2) "कोशिका फाउंडेशन" [illegible]

[illegible] "कोशिका फाउंडेशन" [illegible]

[illegible] "कोशिका" [illegible]

RECOMMENDED FOR ACCEPTENCE
स्वीकृति के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख 01/03/25	Dr.Shibashis Das M.B.B.S M.S Gold Medalist Reg no. 71035 (Name of [illegible] Stamp) [illegible]	(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) [illegible]

FOR INTERNAL USE of KOSHIKA FOUNDATION [illegible]

SIGNATURE of TRUSTEE 1 न्यासी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 न्यासी हस्ताक्षर 2

11.03.2022