

APPLICATION FORM FOR ASSISTANCE सहायता हेतु आवेदन प्रारूप		(Healthcare) (स्वास्थ्य रक्षण)	 Koshika foundation Building block of life.		
APPLICATION No.: K/0624/0267 आवेदन संख्या:		APPLICATION DATE: 07/06/24 आवेदन तिथि			
NAME of APPLICANT: आवेदक का नाम		AGE-YEARS आयु-वर्ष	SEX लिंग		
NETAI MANDAL		76	M		
FATHER'S/SPOUSE'S NAME: पिता/पत्नी का नाम					
SWDHIR MANDAL					
PRESENT RESIDENCE ADDRESS वर्तमान निवास पता					
RAMPUR, SANDESHKHALI-II, NORTH TWENTY					
FOUR PARGANAS 743329 - WEST BENGAL					
PERMANENT RESIDENCE ADDRESS: स्थायी निवास पता					
— AS ABOVE —					
OCCUPATION: उद्योग	ELECTRIC SHOP	MARRIED (विवाहित) / UNMARRIED (अविवाहित)			
TOTAL ANNUAL INCOME: कुल वार्षिक आय	5000x12 = 60,000/-	(Attach Proof of Income) (आय का साक्ष्य संलग्न करें)			
PAN No. स्वामी यात्रा संख्या					
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय करदाता हैं? (जो मध्य हो उस पर ताली का चिह्न लगाएं)					
Yes / हाँ No / नहीं					
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 से सामान्य संबंध	
1.	NETAI MANDAL	76	M	SELF	
2.	GANGA MANDAL	58	F	WIFE	
3.	SAMIRU MANDAL	41	M	SON	
4.	RISHU MANDAL	38	M	SON	
5.	PAPAS MANDAL	33	M	SON	
Basis for REQUESTING ASSISTANCE (Tick whichever is applicable) सहायता के लिए किसी आधार					
BPL Card (Attach Card Copy) भारतीय सरकार के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)		EWS Certificate (Attach Certificate Copy) जन्य आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)		Ration Card (Attach Copy) उपभोजन कार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	
Any Other Basis/Proof अन्य कोई साक्ष्य					
"PURPOSE" for REQUESTING ASSISTANCE: सहायता हेतु देने को किसी का उद्देश्य:					
Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न				
1.	DIAGNOSIS — CATARACT — LE				
2.	SURGERY — LE (SICS + IOL)				
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 सी गई सहायता राशि		

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.

- [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 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 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 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.

- [illegible]

अभ्यर्चना से हस्ताक्षर या अंगुठी का निशान



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 it's 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 & it's outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.

[illegible]

- [illegible]

2. "बोसिफ कान्स्टेन" से तो यह समझ लेता कि वह प्रकृति की ही कृपे से इसका जन्म हो गया, लेकिन वह जो न. कनकाशिम से जुड़ा है, उसका

को छोड़ कर और "कॉरिडोर" को छोड़ भूमिका का निर्माण ही इस मामले में नहीं होगी।

स्वीडिश के लिए संस्कृति

Dr. Subashis Das
M.B.B.S M.S.
Gold Medalist
(Name of Dr. & Regn. No. with Stamp)
डाक्टर का नाम व प्रमाण पत्र के साथ

(Name, Designation & Stamp of Authorised Signatory
on behalf of Hospital)

FOR INTERNAL USE of KOSHIKA FOUNDATION

न्यायी ब्रह्मचर ।

न्यासी इस्लाम २

Defendant

212