

APPLICATION FORM FOR ASSISTANCE (Healthcare)		(स्वास्थ्य देखभाल)		 Koshika Foundation Building block of life.	
APPLICATION No.: 101224 / 1455		APPLICATION DATE: 17/12/24			
NAME of APPLICANT: ANOYARA BIBI		AGE-YEARS: 59		SEX: F	
FATHER'S/SPOUSE'S NAME: LALMIYA MOLLA					
PRESENT RESIDENCE ADDRESS: FIRNAGAR, SHYAMNAGAR, SOUTH 24					
PERMANENT RESIDENCE ADDRESS: FARANAS, WEST BENGAL					
— AS ABOVE —					
OCCUPATION: HOME MAKER		MARRIED (विवाहित) / UNMARRIED (अविवाहित)			
TOTAL ANNUAL INCOME: 4000 X 12 = 48,000/-		(Attach Proof of Income)			
ARE YOU AN INCOME TAX ASSESSEE (Yes/No) ☒ Yes / ☐ No					
FAMILY DETAILS परिवार विवरण					
Sr. No.	Name of Family Member	Age (Years)	Gender	Relation with Applicant	
1.	ANOYARA BIBI	59	F	SELF	
2.	RAFIK MOLLA	54	M	HUSBAND	
3.	MANIRUL MOLLA	30	M	SON	
4.	SARIFUL MOLLA	29	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:					
Sr. No.	Medical Report/Prescription Attached				
1.	DIAGNOSIS — CATARACT — RE				
2.	SURGERY — RE (SLC + IOL)				
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES					
Sr. No.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED			

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.

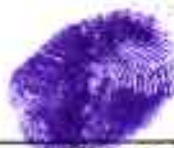
- AGREEMENT by APPLICANT (सहस्रकृता एतत् कृतम्)**

- 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 अपने उत्तराक्षर या फोटो की सहायता, में (अर्थात्क) अपनी सहायता की सुविधा है जब "कोलिका कावरेटिन और उसके व्यक्तियों" को संविष्टत कहा है कि मेरा नाम, माता, फोटो और जो विवरण इस प्रश्न में कोलिका है, उसे "कोलिका" समझ लें, जो, सचमुच सही मूल्य से मुझे लीमिटेड को जल्दियों के बिना किसी भी प्रकार कावरेटिन से प्रभावित करने के लिए संविष्टत है। मैं प्रश्न का विवरण में उत्तर के पहले या बाद में करने के लिए "कोलिका कावरेटिन" न लेंगी संविष्टत है।
- 2) मैं (अर्थात्क) इस बात से सहमत हूँ कि मेरा नाम, माता, फोटो और विवरण के जो सहायता के व्यक्तियों के प्रभाव है मुझे सही सहायता का समझ नहीं आता। इस सहायता में "कोलिका" समझ उसके व्यक्तियों का निर्णय संविष्टत और सचमुच सही कहा।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

अभियन्ता को प्रभावकार वा मर्मणे का निरास



AGREEMENT by HOSPITAL (remains your work)

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 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.

इससे स्पष्ट है, इसलिए भी उसे से सम्बन्धित को "बोलीया चालीया" से मिली चालीया से सम्बन्धित भी नहीं है, जिसे हम (हमारे) निम्न प्रकार से मान्य व समझते हैं:

- [illegible]

RECOMMENDED FOR ACCEPTANCE

कर्मियों के लिए संसाधन

Date of Surgery
ऑपरेशन की तारीख

17 | 12 | 24

Dr. Shibashis Das

M.B.B.S M.S.
Gold Medalist

(Name of Dr. or Regn. No. with Stamp)

अथ नमः य इत्यादि य इति न

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

नाम व पद सम्मान स्वीकृत स्थिति

FOR INTERNAL USE of KOSHIKA FOUNDATION ग्रन्थीक उपयोग हेतु

SIGNATURE of TRUSTEE 1

न्यासी हस्ताक्षर ।

SIGNATURE of TRUSTEE 2

संयोजक २

Exempel

Herb