DEL-4-22-12-6855

APPLICATION FORM FOR ASSISTANCE (Healthcare)
सहायता हेतु आवेदन प्रारूप (स्वास्थ्य देखभाल)

Koshika foundation
Building Block of Life

APPLICATION No आवेदन संख्या	E/0525/0057	APPLICATION DATE आवेदन तिथि	20/5/25
NAME of APPLICANT आवेदक का नाम	GULAAM MUKAJAKKIR	AGE-YEARS आयु वर्ष	02 YEARS
		SEX लिंग	MALE

FATHER'S/SPOUSE'S NAME पिता/पति का नाम: MOHD MUZAMMIL (FATHER)

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता: BANK WARD NO - 10 BANK BEGUSARAI, JARH-MUNIA, BIHAR - 851211.

PERMANENT RESIDENCE ADDRESS स्थाई आवासीय पता:

OCCUPATION व्यवसाय: AUTO DRIVER (FATHER)

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME कुल वार्षिक आय: 1,44,000 (FATHER) (Attach Proof of Income) (आय का साक्ष्य संलग्न)

PAN No. पैन संख्या:

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता है (जो लागू हो उस पर सही का निशान लगाये) Yes / No हां / 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 के साथ सम्बंध
1.	MOHD MUZAMMIL	38	MALE	FATHER
2.	RESHAMI KHATUN	33	FEMALE	MOTHER
3.	FUKRAN	03	MALE	BROTHER
4.	MD. KASIM	59	MALE	GRANDFATHER
5.	ANISA KHATUN	57	FEMALE	GRANDMOTHER

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

BPL Card (Attach Card Copy) गरीबी रेखा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) अल्प आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) राशनकार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	Any Other Basis/Proof ~~अन्य कोई साक्ष्य~~

"PURPOSE" for REQUESTING ASSISTANCE:
सहायता हेतु किये गये निवेदन का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न
1.	DIAGNOSIS - RETINOBLASTOMA.
2.	TREATMENT - EYE

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्त्रोत से लिया गया हो? NO

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्त्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशी
	NIL	

DECLARATION by APPLICANT (आवेदक द्वारा घोषणा पत्र)

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) [illegible]
2) [illegible]
3) [illegible]

AGREEMENT by APPLICANT (आवेदक द्वारा करार)

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.

1) [illegible]
2) [illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :
[illegible]

मो० मो० उर्मिल

AGREEMENT by HOSPITAL (हस्पताल द्वारा करार)

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 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]
1) [illegible]
2. [illegible]

RECOMMENDED FOR ACCEPTENCE
स्वीकृती के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख		
23/5/25	Dr. CHHAVI GUPTA (Name of Dr. & Regn. No. with Stamp) डॉक्टर का नाम व पंजीकरण संख्या मोहर के साथ Regd. No. 100745	Dr. SIMA DAS (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) Oculoplasty Services Regd. No. 9609 Dr. Shroff's Charity Eye Hospital

FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 न्यासी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 न्यासी हस्ताक्षर 2
[signature]	[signature]

30-11-2024

Dr. Shroff's Charity Eye Hospital

Caring for the community since 1914...

Dr. Shroff's Charity Eye Hospital Delhi is Now NABH Accredited

31st May 2025

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Mast. Gulaam Mukajakkir- **E/0525/0057**

Estimate cost of treatment Dr. Shroff's Charity Eye Hospital *Retinoblastoma Surgeries*					
Name		Mast. Gulaam Mukajakkir	**Address/ Phone:**	Bank ward no-10,Bank Begusarai,Lakhmirua,Bihar-851211	
MR N		DEL-G-22-12-6855	**Age/Sex**	2 years	Male
S. No.	**Treatment date**	**Items**	**Cost per Unit**	**No. of unit**	**Aprox. Cost**
1	22/05/2025	Examination under anesthesia	2000	1	2000
		Total			**2000**

Best Regards

Dr. Sima Das

Director

Oculoplasty and Ocular Oncology Services

DR. SHROFF'S CHARITY EYE HOSPITAL

5027, Kedar Nath Road Daryaganj, New Delhi-110002 India

Ph:- 011-4352 4444, 4352 8888, Fax : 011-43528816

E-mail : sceh@sceh.net, Website : www.sceh.net

OTHER CENTRES

ALWAR • SAHARANPUR • MEERUT • LAKHIMPUR KHERI • VRINDAVAN • KAROL BAGH (DELHI)