DEL-G-24-06-4851

APPLICATION FORM FOR ASSISTANCE (Healthcare)

सहायता हेतु आवेदन प्रपत्र (स्वास्थ्य देखभाल)

Koshika foundation

APPLICATION No.	E/1124/0240
APPLICATION DATE आवेदन तिथि	01/11/24
NAME of APPLICANT आवेदक का नाम	KAVYA
AGE-YEARS आयु-वर्ष	2 YEARS
SEX लिंग	FEMALE
FATHER/SPOUSE'S NAME पिता/पति का नाम	ARUN KR GUPTA (FATHER)

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

H/no. - 37, SANTOSH NAGAR, BANDA, UTTAR PRADESH, 210128

PERMANENT RESIDENCE ADDRESS स्थाई आवासीय पता

OCCUPATION व्यवसाय	COSMETIC SHOPKEEPER (FATHER)
MARRIED (विवाहित) / UNMARRIED (अविवाहित)	UNMARRIED
TOTAL ANNUAL INCOME वार्षिक आय	96,000 (FATHER) (Attach Proof of Income आय का प्रमाण संलग्न करें)
PAN No. पैन नंबर यदि हो	
ARE YOU AN ACTIVE TAX ASSESSEE (Tick whichever is applicable) क्या आप आयकर दाता हैं (जो लागू हो उस पर सही का चिह्न लगाएं)	Yes / No हाँ / नहीं

FAMILY DETAILS परिवार विवरण

Sr. No. क्र. संख्या	Name of Family Member परिवार के सदस्य का नाम	Age (Years) आयु (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ संबंध
1	ARUN KR GUPTA	32	MALE	FATHER
2	NEHA GUPTA	32	FEMALE	MOTHER
3	AARVI	3 YEARS	FEMALE	SISTER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

सहायता के लिए किसके आधार

BPL Card (Attach Card Copy) गरीबी रेखा के नीचे प्रमाण पत्र (प्रमाण पत्र की प्रति प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आर्थिक रूप से कमजोर प्रमाण पत्र (प्रमाण पत्र की प्रति प्रति संलग्न करें)	Ration Card (Attach Copy) राशनकार्ड (प्रमाण पत्र की प्रति प्रति संलग्न करें)	✓ Any Other Basis (Proof) अन्य कोई आधार

"PURPOSE" for REQUESTING ASSISTANCE

सहायता हेतु किसे एवं किसलिये का उद्देश्य:

Sr. No. क्र. संख्या	Medical Reports/Prescriptions Attached चिकित्सक/डॉक्टर से प्राप्त की गई प्रतिवेदन सूची संलग्न
1.	DIAGNOSIS - RETINOBLASTOMA
2.	PROCEDURE - GENETIC TEST.

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

इस उद्देश्य के लिए क्या अन्य स्रोतों से सहायता लिया जा रहा है? NO

Sr. No. क्र. संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED सहायता राशि
	NA	

AGREEMENT by APPLICANT (आवेदक द्वारा करार)

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION

AGREEMENT by HOSPITAL (अस्पताल द्वारा करार)

RECOMMENDED FOR ACCEPTENCE
स्वीकृति के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख		
08/11/24	Dr. CHHAVI GUPTA Adjunct Consultant, Oculoplasty and Ocular Oncology Services Regd. / Stamp (Name of Dr. & Regn. No.)	Dr. SIMA DAS Director Oculoplasty and Ocular oncology services Director, Medical Education Department (Authorised Signatory of Hospital)

FOR INTERNAL USE of KOSHIKA FOUNDATION

SIGNATURE of TRUSTEE 1 ट्रस्टी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 ट्रस्टी हस्ताक्षर 2

15-08-2023

Dr. Shroff's Charity Eye Hospital

Caring for the community since 1927

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

30th November 2024

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Baby. Kavya Kavya- E/1124/0240

Estimate cost of treatment Dr. Shroff's Charity Eye Hospital *Retinoblastoma Surgeries*					
Name		Baby. Kavya Kavya	Address/ Phone	H no. 37, Santoshi Nagar, Banda, Uttar Pradesh-210001	
MR N		DEL-G-24-06-4851	Age/Sex	2 years	Female
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Aprox. Cost
1	11/6/2024	Chemotherapy	2500	1	2500
		Total			**2500**

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) ● MODI NAGAR ● RANIKHET