

AMOUNT of ASSISTANCE BEING AVAILED
 लौ गई सहायता रकम

DECLARATION by APPLICANT: आवेदनकृत द्वारा घोषणा कर:

- 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) मैं यहाँ पर कक्षा में कि इस प्रकार से दिने गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही है। यदि कोई विवरण एवं कथन असत्य यात्रा है तो मेरी सहमति निरस्त की जा सकती है।
- 2) मेरे द्वारा की सहमति यहाँ "कोशिका फाउन्डेशन", से ली जा रही है, उसका उपयोग उक्त उद्देश्य की पूर्ति के लिये किया जायेगा, जो इस प्रकार में भरा गया है।
- 3) मैं यहाँ पर कक्षा में कि विषय साहाय्य हेतु यह प्रार्थना की गई है, उस राशि का अवशिष्ट या समस्त किसी अन्य प्रोप्रायिटर/कर्मियों/कंपनी को न हो लिया है और न ही भविष्य में लीया।

AGREEMENT by APPLICANT (अवेदक द्वारा फैहर)

- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and its Trustees to use/publish/post-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 its activities/achievements. Such use of my photo & details can be made by Koshika Foundation before or after my treatment or fulfillment 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) इस प्रश्न पर अपने इच्छाएं या आगे की छाप लगाकर, मैं (आवेदक) अपनी सहमति की पुष्टि करता हूँ एवं "कोशिका फाउंडेशन और उसके न्यासीयों" को अधिकृत करता हूँ कि वे मेरा नाम, पता, फोटो और जो विवरण इस प्रश्न में घोषित है, उसे "कोशिका" एवम न्यासी, दान, वसूली/या दूसरे उद्देश्य से जुड़ी गतिविधियों और उपलब्धियों को सितरे किसी भी प्रकार सम्भव से प्रदर्शित करने के लिए अधिकृत है; मेरे प्रश्न का विवरण मेरे इच्छा के पहले यह बात में करने के लिए "कोशिका फाउंडेशन" व न्यासी अधिकृत है।
- 2) मैं (आवेदक) इस बात से सहमत हूँ कि मेरा नाम, पता, फोटो और विवरण जो कि सहायता के उद्देश्य से प्रार्थित है मुझे स्वतः सहायता का हकदार नहीं बनाता। इस सम्बंध में "कोशिका" एवम उसके न्यासीयों का निर्णय अंतिम और बाध्यकारी होगा।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

सायबेक के हस्ताक्षर या जंगूटे का निशान

self

AGREEMENT by HOSPITAL (हस्पताल द्वारा करा)

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

RECOMMENDED FOR ACCEPTENCE

स्वीकृती के लिए संसुति

Date of Surgery
ऑपरेशन की तारीख

12-9-25

Dr. SUNIL VERMA

DMC No. 420634

Name of Dr. & Regn. No. with Stamp:

डाक्टर का नाम व इलाखर व रसि. न

(Name, Designation & Stamp of Authorised Signatory)

on behalf of Hospital

FOR INTERNAL USE of KOSHIKA FOUNDATION

आन्तरिक दृष्टिकोण हेतु

SIGNATURE of TRUSTEE 1

न्यासी इत्यादि ।

Erklärung

SIGNATURE of TRUSTEE 2

न्यासी दत्तात्रय ३

Rich