

SRE-C-26-03-0499

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)

Koshika
foundation

Building block of life

APPLICATION No.
आवेदन संख्या :

S/0326/0982

APPLICATION DATE :
आवेदन तिथि

11/3/26

NAME of APPLICANT
आवेदक का नाम

Mrs. Dulani

AGE-YEARS आयु-वर्ष

61

SEX लिंग

F

FATHER'S/SPOUSE'S NAME
पिता/पति का नाम

Late Mr. Rajkumar

PRESENT RESIDENCE ADDRESS : वर्तमान आवास का पता

HOUSE NO - 107, HIRANMANGAL,
Lakhnau, Saharanpur,
Uttar Pradesh - 247341

PERMANENT RESIDENCE ADDRESS : स्थायी आवास का पता

Same as above



PASTE PHOTO HERE

Pre op Post op
Dulani
(0982)OCCUPATION
व्यवसाय

Home Maker

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME
कुल वार्षिक आय

78,000 / Family Income

(Attach Proof of Income)

(आय का साक्ष्य संलग्न करें)

NA

PAN No. आय का पत्र संख्या

NA

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable):
क्या आप आय कर कादाता हैं? (जो मान्य हो उस पर सही का निशान लगाएं)

Yes / No

हाँ / नहीं

FAMILY DETAILS परिवार विवरण

Sl. No. क्रम संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक से संबंध
(1)	Nagendra	35	M	Son
(2)	Nisha	23	F	Daughter in law
(3)	Naman	10	M	Grand Son
(4)	Prince	03	M	Grand Son

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

BPL Card (Attach Card Copy) गरीबी रक्षा के तहत प्रमाण पत्र (प्रमाण पत्र की छापी प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आयु वर्ग 1-10 लाख तक (प्रमाण पत्र की छापी प्रति संलग्न करें)	Ration Card (Attach Copy) उपभोग्यता कार्ड (प्रमाण पत्र की छापी प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई साक्ष्य
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"PURPOSE" for REQUESTING ASSISTANCE:
सहायता हेतु किए गए निशानों का उद्देश्य:Medical Reports/Prescriptions Attached
आस्पताल/डॉक्टर से जारी की गई प्रतिक्रिया सूची संलग्नDiagnosis - RE - Total Cataract
LE - Senile Cataract

Surgery - RE - SICS with PMMA

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से ली जा रही है?

Sl. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशि

DECLARATION by APPLICANT (अर्शक द्वारा घोषणा)

- I hereby declare that all contents in this Form are True to the best of my knowledge. Any false statement will render my Application & ongoing assistance. If any false statement is found, my assistance will be cancelled.
- I hereby 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.
- 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.
- I hereby declare that I am not a member of any political party or any other organization, which is engaged in any political activity.
- I hereby declare that I am not a member of any religious organization, which is engaged in any religious activity.
- I hereby declare that I am not a member of any caste or community organization, which is engaged in any caste or community activity.
- I hereby declare that I am not a member of any trade union or any other organization, which is engaged in any trade union or other activity.
- I hereby declare that I am not a member of any other organization, which is engaged in any other activity.

AGREEMENT by APPLICANT (अर्शक द्वारा करार)

- By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and its Trustees to use/publish/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.
- 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.
- I hereby declare that I am not a member of any political party or any other organization, which is engaged in any political activity.
- I hereby declare that I am not a member of any religious organization, which is engaged in any religious activity.
- I hereby declare that I am not a member of any caste or community organization, which is engaged in any caste or community activity.
- I hereby declare that I am not a member of any trade union or any other organization, which is engaged in any trade union or other activity.
- I hereby declare that I am not a member of any other organization, which is engaged in any other activity.

APPLICANT'S SIGNATURE/LEFT THUMB IMPRESSION:
अर्शक का हस्ताक्षर या बायाँ 엄指 छाप



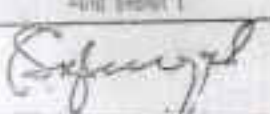
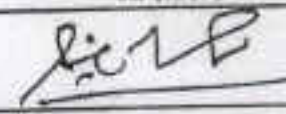
AGREEMENT by HOSPITAL (हस्पताल द्वारा करार)

- We, the undersigned, hereby confirm & accept following:
- That we have not previously 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.
 - That we have not previously 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.
 - That 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 full & complete responsibility of the treatment & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in this regard.
 - I hereby declare that I am not a member of any political party or any other organization, which is engaged in any political activity.
 - I hereby declare that I am not a member of any religious organization, which is engaged in any religious activity.
 - I hereby declare that I am not a member of any caste or community organization, which is engaged in any caste or community activity.
 - I hereby declare that I am not a member of any trade union or any other organization, which is engaged in any trade union or other activity.
 - I hereby declare that I am not a member of any other organization, which is engaged in any other activity.

RECOMMENDED FOR ACCEPTANCE
स्वीकृती के लिए अनुमति

Date of Surgery शल्यक्रिया की तारीख 11/3/26	Dr. NEHA DME No.-58989 (Name of Dr. & Regn. No. with Stamp) डॉक्टर का नाम व इलाका नं. छाप	(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद हस्पताल अधिकृत अधिकारी 
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FOR INTERNAL USE of KOSHIKA FOUNDATION (अन्तर्गत उपयोग हेतु)

SIGNATURE of TRUSTEE 1 माननीय हस्ताक्षर 1 	SIGNATURE of TRUSTEE 2 माननीय हस्ताक्षर 2 
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