

APPLICATION FORM FOR ASSISTANCE (Healthcare)		(सहायता हेतु आवेदन प्रारूप)		 Koshika foundation Building blocks of life.	
APPLICATION No.: W/0618/0453		APPLICATION DATE: 04.06.18			
NAME of APPLICANT: SHUBHADRA PRAMANIK		AGE-YEARS: 58		SEX: F	
FATHER'S/SPOUSE'S NAME: NEMAI PRAMANIK					
PRESENT RESIDENCE ADDRESS: PODULIA, TITAGARAH (M), NORTH 24 PARGANAS, WEST BENGAL				 	
PERMANENT RESIDENCE ADDRESS: AS ABOVE					
OCCUPATION: HOUSE WIFE		MARRIED (विवाहित) / UNMARRIED (अविवाहित)			
TOTAL ANNUAL INCOME: NIL		(Attach Proof of Income)			
PAN No. WMAJ1234K					
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable):		Yes / No			
FAMILY DETAILS					
Sr. No.	Name of Family Member	Age (Years)	Gender	Relation with Applicant	
1.	SHUBHADRA PRAMANIK	58	F	SELF	
2.	NEMAI PRAMANIK	62	M	HUSBAND	
3.	SAMIR PRAMANIK	35	M	SON	
4.	ABUN PRAMANIK	32	M	SON	
5.	SEFALI PRAMANIK	28	F	DAUGHTER	
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:					
Medical Reports/Prescriptions Attached					
Sr. No.	1. TRABANDIS - CATARACT (L)				
Sr. No.	2. SURGERY - L (SUGGESTION)				
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES					
Sr. No.	NAME of OTHER SOURCE		AMOUNT of ASSISTANCE BEING AVAILED		

DECLARATION by APPLICANT: आवेदनक द्वा पावेना नय:

- 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 क़ात हूँ कि इस प्रमाण में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण सत्य/कथन असत्य पाया जाता है तो मेरी सहायता निरस्त की जा सकती है।
- 2) मेरी दृढ़ता के साथ यह प्रति "कोशिका फाउन्डेशन", से ली जा रही है, उसका उपयोग उसी उद्देश्य की पूर्ति के लिये किया जायेगा, जो इस प्रमाण में बता गया है।
- 3) मैं यहाँ पर क़ात हूँ कि जिस सहायता हेतु यह प्रार्थना की गई है, उस प्रति जा अधिक या समस्त विराम किसी अन्य प्रोटेक्टिव/वैयक्तिक कम्पनी से न ली जायेगी और न ही अधिकार में ली जायेगी।

AGREEMENT by APPLICANT (आवेदक द्वारा कबूल)

- 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.

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION

आपके एक ही ब्रह्मदेव का अंगुलि का निरूपण



AGREEMENT by HOSPITAL (हस्ताक्षर प्राप्त करें)

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.

RECOMMENDED FOR ACCEPTENCE

सभीकृती के लिए संभार

Date of Surgery ऑपरेशन की तारीख 04.06.18	Dr. Bindam Deb MBBS, DO, FRCS Reg. No.-58096 (Name of Doctor with Stamp) डॉक्टर का नाम व इम्प्रेस और रजि. नं.	Dr. Shashi Director (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व सह इम्प्रेस और अधिकृत अधिकारी
--	---	---

FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 આચાર્ય હસરતભાઈ ૧	SIGNATURE of TRUSTEE 2 આચાર્ય હસરતભાઈ ૨
	