

DECLARATION by APPLICANT: जातिवृत्त प्रमाण 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 Kashiya 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 यह कह रहा हूँ कि इस प्रश्न में दिये गये सभी विवरण सही जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई भ्रामक एवं असत्य जानकारी दया जाय है तो मेरी प्रार्थना प्रिय श्री केशीया फाउंडेशन है।
- 2) मैं इससे कह रहा हूँ कि "कौशलिक प्रशिक्षण", जो मुझे प्राप्त हो रहा है, इससे प्रत्यक्ष रूप से मेरे जीवन को सुधरे के लिए किया जायेगा, जो इस प्रश्न में कहा गया है।
- 3) मैं यहाँ पर यह कह रहा हूँ कि मैं इस प्रार्थना से पहले या प्रत्यक्ष भी नहीं हूँ, इस राशि का अधिक या कम किसी किसी अन्य स्रोत/रोजगार/बीमा कम्पनी से या से प्राप्त है और मैं इसे भी नहीं हूँ।

AGREEMENT by APPLICANT (below the line)

- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and it's Trustees to use/publish/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 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 तरह का ज्ञान प्रसारण या सेवा की बात समझकर, मैं (आवेदक) अपनी साक्षी की मुद्रा लगाऊँ हूँ कि "कोशिका फाउंडेशन और इसके ट्रस्टियों" को अधिकृत करता है कि वे मेरा नाम, पता और कोई भी विवरण इस उद्देश्य के लिए उपयोग कर सकते हैं, जैसे "कोशिका" द्वारा आयोजित, चलाया, संचालित किये जा रहे कार्यक्रमों में मुझे शामिल करने के लिए जानकारी देना और जानकारी देने के लिए किसी भी प्रकार का माध्यम जिसमें लिखित, मुद्रित, इलेक्ट्रॉनिक, ऑडियो वीडियो, दूरदर्शन, रेडियो, प्रिंट, इत्यादि शामिल हो।
- 2) मैं (आवेदक) इस बात से सहमत हूँ कि मेरा नाम, पता, कोई भी विवरण जो कि प्रसारण के उद्देश्यों के अधीन है मुझे प्राप्त सामान्य या उपचार नहीं करता। इस सम्बंध में "कोशिका" द्वारा उनके ट्रस्टियों का पूर्ण अधिकार और संपत्तिका होता है।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

अधिकांश में प्रमाणित या सीरीज का निम्न



AGREEMENT by HOSPITAL (FURNISH THE NAME)

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 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

पञ्चीकृतौ चो लिपि संस्कारिणि

Date of Surgery अस्त्रोपचार की तारीख 01/01/18	Dr. A. Kundu MBBS, MS Reg. No.-55127 (Name of Doctor & Reg. No. With Stamp) डॉक्टर का नाम व रजिस्ट्रेशन नं. सह स्टैम्प	Dr. Senkar Bagchi Director (Name, Designation & Stamp of Authorized Signatory on behalf of Hospital) डॉ. स. स. बगची निदेशक
FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु		
SIGNATURE of TRUSTEE 1 विश्वसेवा के संस्थापक 1	SIGNATURE of TRUSTEE 2 विश्वसेवा के संस्थापक 2	
		