

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)
(स्वास्थ्य देखभाल)

Koshika
foundation
Building block of life.

APPLICATION No. :
आवेदन संख्या :

13/0119/0482

APPLICATION DATE :
आवेदन तिथि

08/01/2019

NAME of APPLICANT :
आवेदक का नाम

D. Ramachandrar Naidu

AGE-YEARS आयु-वर्ष

74

SEX लिंग

M

FATHER'S/SPOUSE'S NAME :
पिता/कटुम्ब का नाम

Subbiah Naidu

Neat.

PRESENT RESIDENCE ADDRESS वर्तमान आवास पता

Geetha Ice factory, Pilew Town, Pilew,

PERMANENT RESIDENCE ADDRESS : स्थायी आवास पता

Chittoor Dist, Andhra Pradesh

OCCUPATION :
व्यवसाय

unemployed

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME :
कुल वार्षिक आय

₹0,000/- [family income]

(Attach Proof of Income)
(आय का साक्ष्य संलग्न)

PAN No. स्थायी खाता संख्या

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

Yes / No
हां / नहीं

FAMILY DETAILS परिवार विवरण

Sr. No. क्रम संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ सम्बन्ध
No childrens.				

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)
सहायता के लिये विनति आधार

BPL Card (Attach Card Copy) गरीबी रेषा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) अल्प आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) उपभोक्ता कार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई साक्ष्य
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"PURPOSE" for REQUESTING ASSISTANCE:
सहायता हेतु किये गये विनती का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न
	DOV Right Eye
	RS - I.T.C.H + IOL

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

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED सी गई सहायता राशी
	B.W.L.E.H	



0482 0482
Ramachandrar Naidu Ramachandrar Naidu
Pre OP Post OP

DECLARATION by APPLICANT: **अवेकत द्वारा घोषणा पर:**

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. (My/Our Foundation will be used only for the "purpose", as stated in this Form, for which such assistance

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. _____ of _____, in part or in full, from any other source/employer/insurance company, of the amount _____.

2) I solemnly confirm that assistance, if received from National Health Insurance Corporation, 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 घोषणा करता हूँ कि इस प्रकार से दिये गये सभी विवरण मेरी जानकारी के अनुसार सच एवं सही हैं। यदि कोई विवरण सच माना जाय तो उसे मेरी सहायता प्राप्त की जा सकती है।

2) मेरे हृदय जो साक्ष्यक एवम् "कलितव्य साक्ष्यक", से ली जा रही है, इसका उपयोग करो करण को मुझे के सिने किम साक्ष्य, जो इस प्रत्यक्ष में प्राप्त है।

AGREEMENT by APPLICANT (SEEKING DEDUCTION)

1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and it's Trustees to use/publish/put-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 प्रपत्र पर अपने हस्ताक्षर के अंतर्गत जो चार साक्षर, यै (अथवाएक) अपनी साक्षरता की पुष्टि करता है एवं "कोशिका पाठशाला और उसके ग्राहकों" को अधिभूत करता है कि वे संत सच, पक्ष, फंडों और जो विवरण इस प्रपत्र में प्रोविड है, उसे "कोशिका" एगम् ग्राहकों, पक्ष, सच/सच/दूसरे उद्देश से मुझे संविधानिक और उल्लंघनियों के सिद्धे किसी भी प्रकार सम्मन

2) मैं (आपसे) इस बात से सहमत हूँ कि मैं आप, पाक, जेम्स और विजय को कि साक्षात् के अर्थों में प्रेषित है मुझे नहीं; साक्षात् का अर्थ नहीं होता। इस सम्बंध में "कॉलिंग" प्रत्येक उलझे न्यायीयों का निर्णय अंतिम और बाध्यकारी होगा।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

सुबेरा को इसावा या लंगूटे का निग्रह



AGREEMENT by HOSPITAL (हस्ताक्षर द्वारा स्वीकृति)

By affixing hereunder, signature of our Authorised Signatory for recommending this case/patient for financial assistance from Koshita 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.

[illegible]

2. "कंसिन्हा फरन्डेशन" से भी मैं साक्षात् संबंध स्थापित प्रवृत्ति थी है। ऐसा पर इम्पलेंट द्वारा ही मैं जानता था कि वे गरीबों के जीवन को सुधारा देने के लिए काम कर रहे हैं। इसलिए इम्पलेंट में ऐसी के इलाज शुरू करें और जाने की तारी दिनेली ऐसी एवं इम्पलेंट की होती और "कंसिन्हा" की लोई सुधारा का निर्माण ही इस मामले में जारी होनी।

RECOMMENDED FOR ACCEPTANCE
 एनिकाटी के लिए संस्तुति

Date of Surgery
ऑपरेशन की तारीख

Dr. SHEETAL BALLAL
Consultant

(Name of Dad/Rhino, Mr./Ms./Stamp)
 W. I agree to use the rhinoceros as my inspiration

(Name, Designation & Stamp of Authorised Signatory)

A den tist at a hospital

U. W. L. *University of Wisconsin Library Collection*

the institutions Eye Hospital Road

1008 J.C. Road, Bangalore - 560 002

SIGNATURE of TRUSTEE 1

ज्योती भूतनाथ ।

SIGNATURE of TRUSTEE 2

ज्यामी इत्यादी २