

APPLICATION FORM FOR ASSISTANCE
सहायता हेतु आवेदन प्रारूप

(Healthcare)
(स्वास्थ्य देखभाल)



APPLICATION No.: K/0119/2356
आवेदन संख्या:

APPLICATION DATE: 08/01/19
आवेदन तिथि

NAME of APPLICANT: MADHURI BISWAS
आवेदक का नाम

AGE-YEARS: 61
वर्ष

SEX: F.
लिंग

FATHER'S/SPOUSE'S NAME: DHIRENDRA NATH BISWAS.
पिता/सहोदर का नाम

PRESENT RESIDENCE ADDRESS: वर्तमान आवासीय पता

83 VIVEK NAGAR, JETAJAGRAH, NORTH 24.
BARKHANA 700110, WEST BENGAL

PERMANENT RESIDENCE ADDRESS: स्थायी आवासीय पता

— AS ABOVE —



OCCUPATION: HOUSE WIFE
व्यवसाय

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME: NIL.
कुल वार्षिक आय

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

PAN No. प्राप्त होता है/संख्या

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable):
क्या आप आय कर दाता हैं (जो सत्य 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 सदस्य का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ सम्बन्ध
	MADHURI BISWAS	61	F	SELF
	CHANDRA CHANDRA BISWAS	40	M	HUSBAND
	SUSHY BISWAS	38	M	SON
	MANUSAREL CHANDRAN	34	F	DAUGHTER

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

BPL Card (Attach Card Copy) पोषी रेशन कार्ड का प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आय आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) उपभोग्य कार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई सबूत
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"PURPOSE" for REQUESTING ASSISTANCE:

सहायता हेतु किये गये विनोद का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिक्रिया सूची संलग्न
1.	DIAGNOSIS- CATARACT- RE.
2.	SURGERY RE (SURGICAL)

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

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

DECLARATION by APPLICANT: ज्ञानेश्वर दत्त शर्मा या:

- 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 बताना चाहूँ कि इस प्रारूप में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण पूर्व कथन अलग सत्य साबित हो तो मेरी सहायता प्राप्त भी हो सकती है।
- 2) मैं इस बात का गारंटी करता हूँ कि "कौशिका फाउंडेशन", से ली जा रही है, उसका उपयोग उन्ही उद्देश्यों को पूर्ण करने के लिये किया जाएगा, जो इस प्रारूप में उल्लेखित हैं।
- 3) मैं यहाँ पर बताना चाहूँ कि मैं इस सहायता से प्राप्त की जा रही है, उस पर किसी भी प्रकार का प्रतिफल या भुगतान प्राप्त करने के लिये किसी भी अन्य स्रोत/रोजगार/बीमा कम्पनी से नहीं ले रहा हूँ और न ही भविष्य में ऐसा करूँगा।

AGREEMENT by APPLICANT (sole proprietor)

- 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/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 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.

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

अमेरिका में दृष्टान्त का अर्थ है



AGREEMENT by HOSPITAL (FURNISH THE WORD)

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 ACCEPTANCE

स्वीकृति के लिए संलग्न

Date of Surgery अस्त्रोपचार की तारीख 08-01-2019	Pr. Arghya Das MBBS, MS Reg. No. 69372 (Name of Dr. & Regn. No. with Stamp) डॉक्टर का नाम व इलाका व पंजी. नं.	Dr. Sankar Bagchi Director Cancer Foundation & Research Centre (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद इलाका के अधिकृत अधिकारी
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FOR INTERNAL USE of KOSHIKA FOUNDATION भारतीय उपत्यका क्षेत्र

SIGNATURE of TRUSTEE 1 ज्योती इरावत 1	SIGNATURE of TRUSTEE 2 ज्योती इरावत 2
	