

APPLICATION FORM FOR ASSISTANCE (Healthcare)		(सहायता हेतु आवेदन प्रारूप)		(स्वास्थ्य देखभाल)	
 Koshika Foundation Building Smiles of Life					
APPLICATION No.: K/0119/ 2447		APPLICATION DATE: 11.01.2019			
NAME of APPLICANT: MAHADEB DAS		AGE-YEARS: 65	SEX: M		
FATHER'S/SPOUSE'S NAME: HAZARILAL DAS					
PRESENT RESIDENCE ADDRESS: MAZRUL NAGAR DAS PARA, KHASBALANDA, HAROH, NORTH 24 PARGANAS, 743425, WEST BENGAL					
PERMANENT RESIDENCE ADDRESS: — AS ABOVE —					
OCCUPATION: UNEMPLOYED					
MARRIED (विवाहित) / UNMARRIED (अविवाहित)					
TOTAL ANNUAL INCOME: NIL				(Attach Proof of Income)	
PAN No. [Blank]				Yes / No	
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable):				Yes / No	
FAMILY DETAILS परिवार विवरण					
Sr. No.	Name of Family Member	Age (Years)	Gender	Relation with Applicant	
1.	MAHADEB DAS	65	M	SELF	
2.	SANDHA DAS	64	F	WIFE	
3.	ACHARYA DAS	32	M	SON	
4.	SURAJ DAS	29	M	SON	
5.	AMITA DAS	26	F	DAUGHTER	
6.	SABITA DAS	24	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:					
सहायता हेतु किसे एवं किससे मदद चाहिए:					
Sr. No.	Medical Reports/Prescriptions Attached				
1.	DIAGNOSIS - CATARACT - LE				
2.	SURGERY - LE (SLCS + IOL)				
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES					
इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिये गया है?					
Sr. No.	NAME of OTHER SOURCE		AMOUNT of ASSISTANCE BEING AVAILED		

DECLARATION by APPLICANT: ज्ञातेक दुः खेवण पः

- 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 हूँ कि इस प्रमाण पत्र में दी गई जानकारी सही और सत्य है। यदि कोई भी गलत सूचना या झूठ का दावा किया जायेगा तो मेरी अर्जित सहायता निरस्त की जा सकती है।
- 2) मैं यहाँ पर बताना हूँ कि "कॉशिका फाउंडेशन" से मिली यह राशि है, उसका उपयोग उम्मीदवार को खुद के निर्दिष्ट किए गए कार्य, जो इस प्रमाण पत्र में बताए गए हैं।
- 3) मैं यहाँ पर बताना हूँ कि मैं किसी भी अन्य स्रोत से या अपने नियोक्ता या बीमा कम्पनी से या किसी भी अन्य स्रोत से इस राशि के लिए पूरा भुगतान नहीं कर रहा हूँ।

AGREEMENT by APPLICANT (जिल्हा प्रमुख वरिष्ठ)

- 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 या अंगूठा छाप लगाकर, मैं (आवेदक) अपनी जानकारी को पुष्टि करता हूँ एवं "कोशिका फाउंडेशन और इसके भरोदारों" को अधिकृत करता हूँ कि वे मेरा नाम, पता, फोटो और जो विवरण इस प्रपत्र में दीया है, उसे "कोशिका" एवम् जगदीश, राज, राजकमल द्वारा उद्देश्य से जुड़ी गतिविधियों और उपलब्धियों के लिए किसी भी उचित माध्यम से प्रकाशित करने के लिए अधिकृत है। मैं प्रपत्र का विवरण भी इसका जो पता या कार में करने के लिए "कोशिका फाउंडेशन" व जगदीश अधिकृत है।
- 2) मैं (आवेदक) इस बात से सहमत हूँ कि मेरा नाम, पता, फोटो और विवरण को कि सहायता के उद्देश्यों से प्रसारित है जुझे स्पष्ट: सहायता का इस्तेमाल नहीं करता। इस सम्बंध में "कोशिका" एवम् उसके भरोदारों का निर्णय अंतिम और बाध्यकारी होगा।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

जल्द ही हमारे पास आने का निश्चय



AGREEMENT by HOSPITAL (TAKAHASHI HOSPI TAL)

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

स्वीडिश के लिए संस्कृति

Date of Surgery ऑपरेशन की तारीख 11.01.2019	Dr. K. Ghosh MBBS, DO, DNB, FRCS Reg. No. - 50971 (Name of Dr. A Regd. No. with Stamp)	Dr. Sankar Bagchi Director (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) यह स.प.न. इसका अधिकृत अधिकारी
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FOR INTERNAL USE of KOSHIKA FOUNDATION ગ્રંથાલિકા સંપર્કમાં રહે

SIGNATURE of TRUSTEE 1 न्यासी इन्द्रधर 1	SIGNATURE of TRUSTEE 2 न्यासी इन्द्रधर 2
	