

APPLICATION FORM FOR ASSISTANCE (Healthcare)				(सहायता हेतु आवेदन प्रारूप)		(स्वास्थ्य देखभाल)	
APPLICATION No. : K/0110/2409				APPLICATION DATE : 22/04/19			
NAME of APPLICANT : SUBASH PAUL				AGE-YEARS : 75		SEX : M	
FATHER'S/SPOUSE'S NAME : SUKHAMOY PAUL							
PRESENT RESIDENCE ADDRESS : 69 LAMBAGAN BANIHATI NORTH 24 PARGANAS							
PERMANENT RESIDENCE ADDRESS : - AS ABOVE -							
OCCUPATION : UNEMPLOYED				MARRIED (विधवा) / UNMARRIED (अविधवा)			
TOTAL ANNUAL INCOME : NIL				(Attach Proof of Income)			
PAN No. : [Blank]							
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.	SUBASH PAUL	75	M	SELF			
2.	RANJANA PAUL	62	F	WIFE			
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	
[Blank]		[Blank]		[Blank]		[Blank]	
"PURPOSE" for REQUESTING ASSISTANCE:							
Medical Reports/Prescriptions Attached							
Sr. No.	[Blank]						
1.	DIAGNOSIS - CATARACT - LE						
2.	SURGERY - LE (SICSTOL)						
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES							
Sr. No.	NAME of OTHER SOURCE			AMOUNT of ASSISTANCE BEING AVAILED			
1.	[Blank]			[Blank]			
2.	[Blank]			[Blank]			
3.	[Blank]			[Blank]			
4.	[Blank]			[Blank]			



DECLARATION by APPLICANT: सर्वोदय द्वा विरल वर

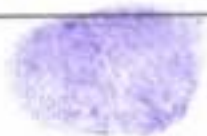
- 1) I hereby confirm that all details in this Form are True to the best of my knowledge. Any false statement will render my Application & ongoing assistance, if any, liable for rejection/cancellation.
- 2) I solemnly confirm that assistance, if received from Koshika Foundation, will be used only for 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 कतार दे रहा हूँ कि इस प्रमाण पत्र में दिये गये सभी विवरण सही जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण सत्य नहीं माना जाय तो मेरी प्रार्थना निराश हो जा सकती है।
- 2) मैं इससे प्राप्त राशि "कोशिका फाउंडेशन", से लेता हूँ। इसका उपयोग उक्त उद्देश्य को पूर्ण करने के लिये किया जायेगा, जो इस प्रमाण पत्र पर उल्लेख है।
- 3) मैं यहाँ पर कतार दे रहा हूँ कि मैं इस प्रमाण पत्र पर उल्लेख की राशि है, उस राशि का अधिकतम या समस्त हिस्सा किसी अन्य सोर्स/एम्प्लॉयर/इन्सुरेन्स कंपनी से न ले रहा हूँ और न ही भविष्य में लेऊँ।

AGREEMENT by APPLICANT (attach per unit)

- 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/post-up/produce 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 :

[illegible]

AGREEMENT by HOSPITAL (WHICH ITU WOK)

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.

इससे जलमयूर, कालावर्षी को जोर से घालने/लेने को "कॉलिका पञ्चमेलन" से विविध खाद्यपद हेतु विपरीत की जाती है, जिसे इन (वर्णमाला) निम्न प्रकार से नाम प प्रयोग करते हैं।

- 1) यह कि न तो सर्वप्रथम और न ही अन्तिम में जितनी सहायता किसी भी साक्षरी संस्था या किसी अन्य उद्योग से उक्त ऐंटी-ट्रस्टों में ली जा ले ली है, वैसी कि अपने "भौतिक फायदेना" से विपरीत/विचित्री उक्त के सम्बंध में "भौतिक फायदेना" द्वारा गहरा हो कि है। यदि "भौतिक फायदेना" द्वारा सहायता विचित्री अतिरिक्त/अवगत हो पाया नहीं किंचित जहां है तो अवगत किन्ती अन्य कि साक्षरी संस्था या किसी अन्य संस्थाओं से सहायता लेने का अधिकार सुरक्षित रहता है। इस धृष्टि में स्पष्ट कहा जाता है कि अवगत विचित्री गहरा उक्त ऐंटी-ट्रस्टों में हो किन्ती कि साक्षरी संस्था या किसी अन्य संस्था से नहीं हो पायेगी।

2. "कोशिका फायरेन्स" के लो र्व सहायता केवल विविध प्रकृति की है। ऐसी या इन्सुलिन ट्राइ पी र्व सहायता या बिने र्वने उपचार/प्रक्रिया का मुख्य ऐसी र्व इन्सुलिन के बीच का विषय है और "कोशिका फायरेन्स" ट्राइ किसी प्रकार का कोई रक्ता नहीं है। इसलिये इन्सुलिन में ऐसी कं इन्सुलिन मुख्य और जने जने की सारी जिम्मेदारी ऐसी र्व इन्सुलिन की होती और "कोशिका" की कोई प्रतिक्रिया या जिम्मेदारी इस मामले में नहीं होती।

RECOMMENDED FOR ACCEPTENCE

स्वीकृती के लिए संस्तुति

Date of Surgery
ऑपरेशन की तारीख

22/01/19

Dr. K. Ghosh
BBS, DO, DNB, FRCS
Reg. No.-50971

(Name of Dr. & Regn. No. with Stamp)

हमसुत का नम व हस्तका व लैव ३

(Name, Designation & Stamp of Authorised Signatory
on behalf of Hospital)

राम व पद इत्यन्तान् अधिकृत अधिकारी

FOR INTERNAL USE of KOSHIKA FOUNDATION

आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1

म्यामी इम्प्राया ।

Erklärung

SIGNATURE of TRUSTEE 2

ज्यामी इस्तेमाल 2

2020