

APPLICATION FORM FOR ASSISTANCE (Healthcare)		(स्वास्थ्य देखभाल)		
सहायता हेतु आवेदन प्रारूप		(Healthcare)		
KOSHKA FOUNDATION Building block of life.				
APPLICATION No.: K/0519/0299		APPLICATION DATE: 17/05/19		
NAME of APPLICANT: MANJU HALDAR		AGE-YEARS: 43	SEX: F	
FATHER'S/SPOUSE'S NAME: YUDHISHTHIR HALDAR				
PRESENT RESIDENCE ADDRESS: JAMALA ISWARSUR RULPT, SOUTH 24 PARGANAS 743359, WEST BENGAL				
PERMANENT RESIDENCE ADDRESS: AS ABOVE				
OCCUPATION: HOUSE WIFE		MARRIED (विवाहित) / UNMARRIED (अविवाहित)		
TOTAL ANNUAL INCOME: RS. 2000 x 12 = 24000/-		(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	MANJU HALDAR	43	F	SELF
2	YUDHISHTHIR HALDAR	53	M	HUSBAND
3	KAILASH HALDAR	26	M	SON
4	PALASH HALDAR	23	M	SON
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:				
Medical Reports/Prescriptions Attached				
Sr. No.	1. DIAGNOSIS - CATARACT - LE			
Sr. No.	2. SURGERY - LE (SIXES + LOLS)			
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES				
Sr. No.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED		
Sr. No.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED		

DECLARATION by APPLICANT: आवेदक द्वारा घोषणा पत्र:

- DECLARATION by APPLICANT: **अभ्यर्थक 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.
 - 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 घोषणा करता हूँ कि इस फॉर्म में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण एवं कथन असत्य पाया जाता है तो मेरी सहायता निरस्त की जा सकती है।
- 2) मैं यहाँ घोषणा करता हूँ कि "कोशिका फाउन्डेशन", से ली जा रही है, उसका उपयोग उसी उद्देश्य की पूर्ति के लिये किया जायेगा, जो इस फॉर्म में माँगा गया है।
- 3) मैं यहाँ घोषणा करता हूँ कि जिस सहायता हेतु यह प्रार्थना की गई है, उस राशि का अतिरिक्त या समस्त हिस्सा किसी अन्य स्रोत/नियोक्ता/बीमा कम्पनी से न ले लिया है और न ही भविष्य में लूँगा।

AGREEMENT by APPLICANT (सहितक प्रु वरु)

- 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.

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

आपके कर्मचारियों को प्रशिक्षण देना शुरू करें



AGREEMENT by HOSPITAL (हस्पताल द्वारा करार)

By affixing hereunder, signature of our Authorised 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.

हमारे अधिपति, इसलिये की ओर से मानदेयों की "कोशिका पाठ्यपुस्तक" से विविध सामग्री हेतु विक्रीका की जाती है, जिसे इन (इम्प्लान्त) विन प्रकार से खाने व पीने का इस्तेमाल करते हैं।

- 1) यह कि न तो संसदन और न ही पंचायत में विधि सभागत किसी भी सारकारी संस्थान या किसी अन्य इकाई से उक्त ऐंगी/पायले में लेंगे या ले रहे हैं, जैसे कि हमने "कोशिका पाउन्डेशन" से सिपरीस/विपरीत उक्त के सम्बंध में "कोशिका पाउन्डेशन" द्वारा मरद हेतु कि है। यदि "कोशिका पाउन्डेशन" द्वारा सहायता विपरीत अतिरिक्त/सकल हेतु मन्त्रु नहीं किया जाता है तो असम्भव किसी अन्य भी सारकारी संस्था या किसी अन्य संस्थापन से सहायता लेने का अधिकार सुरक्षित रखता है। इस पृष्ठ में स्पष्ट कहा जाता है कि असम्भव द्वितीय मरद उक्त ऐंगी/पायले हेतु किसी भी सारकारी संस्था या किसी अन्य संस्थान से नहीं लेगा/लेगी।
2. "कोशिका पाउन्डेशन" से ही यह सहायता केवल विधि प्रकृति की है। ऐंगी पर हमसकल द्वारा ही यह सारक या किये गये उपचार/प्रक्रिया का पुराण ऐंगी एवं हमसकल के बीच का विषय है और "कोशिका पाउन्डेशन" द्वारा किसी प्रकार का कोई दबाव नहीं है। इसलिये हमसकल में ऐंगी के द्वारा सुझा और आने जाने की सारी जिम्मेदारी ऐंगी एवं हमसकल की होगी और "कोशिका" की कोई भूमिका या जिम्मेदारी इस मामले में नहीं होगी।

RECOMMENDED FOR ACCEPTANCE

स्वीकृति के लिए संसक्ति

Date of Surgery ऑपरेशन की तारीख 17/05/19	Dr. Alok Agrawal MBBS, MS, PhD(Eye) FMRP, FRCS Reg. No. 34786 (Name of Dr. & Regn. No. with Stamp) डॉक्टर का नाम व इस्तफा व रजि नं.	Shib Bakkar Bagchi Director Foundation & Research Centre (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद हस्पताल अधिकृत अधिकारी
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FOR INTERNAL USE of KOSHIKA FOUNDATION

आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 न्यासी इस्तेफार 1	SIGNATURE of TRUSTEE 2 न्यासी इस्तेफार 2
	