Annexure-B

APPLICATION FORM FOR FINANCIAL ASSISTANCE OUT OF OSTF FUND

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1. Name of the Patient (in Block Letters) :- ----------
2. Age :- ----------
3. (A) Permanent Address :- ----------

   (B) Address for Correspondence :- ----------

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5. Whether the Applicant or the person :- ----------
   on whom He/She depends is an :- ----------
   Employee of Centre/State Govt. ----------
6. Name of the Applicant if the :- ----------
   Application is not made by the ----------
   Patient. ----------
7. Application's Relationship to the ----------
   Patient.
8. Disease from which suffering :- ----------
9. Name of Hospital where the treatment :- ----------
   is being received. ----------
10 BPL card No (Only-1997) :- ----------
   (Enclosed Photocopy of BPL card No.)
11. Income of the patient/parent, (Annual):- ----------
   Duly issued by "Tehsildar "
   (For those having no BPL No.)
12. Quantum of one-time financial :- ----------
   Assistance required. ----------
13. Whether Financial Assistance for the :- ----------
   same purpose (i) has been received ----------
   from (ii) a request has been /is being ----------
   made to some Department/Agency/Authority ----------
   other than the Department of Health & Family ----------
   Welfare, GoO, if so, Give Full Particulars. - ----------
   :- ----------
14. Any Other information

DECLARATION

I Mr./Mrs._____son/ daughter of Mr./Mrs._____ hereby declare that, the information given above is correct and complete in all respects and that I am in no position at all to arrange for /provide funds for the purpose stated above. I also declare that neither I nor my parents are employees of the Central/State Government or a local body.

N:B:- In case it is detected subsequently that, any fraudulent or misleading information has been furnished , the applicant shall be liable for any legal action as deemed fit.

Place
Dated: Signature of the Applicant/Patient.

Annexture-C

TO BE FILLED BY THE NODAL OFFICER OF THE CASE/HOSPITAL ETC.

WHERE THE PATIENT IS RECEIVING THE TREATMENT.

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1. Patient's Name :- _____
2. Name of the Hospital :- ----------
3. Indoor Registration Number :----------
   A short note on the present :----------
   clinical condition of the patient. :----------
4. List of Report of Important :----------
   Investigation Done. :----------
5. Diagnosis ` :----------

6. If the patient has been operated, :----------
   a. the date of operation. :----------
7. Name of the Treating Physicians :----------
8. The Amount of money recommended :----------
1. Item wise Break-up of expenditure
   Of amount recommended at :----------

Name of the consumables/medicines required Cost in Rupees.
for operation/treatment

A)
B)
C)

N:B :- A photocopy of the bed head ticket to be enclosed by the Nodal Officer.

Scrutinised By Verified &Recommended By

Signature of the Nodal Officer Signature Recommending Officer

An amount of Rs._____( ) is recommended for the treatment of patient vide Cheque No_____//Date_____.

Approved By

Signature of the Medical Superintendent
In charge of the Hospital/ CDMO/CMO
With Official Seal.