SHRI JINKUSHAL SURI FOUNDATION

E-46, INDUSTRIAL AREA, BATHINDA

REGISTRATION NO. 0677 OF 2001

Mob. 94632-53901, E-mail: shrijinkushalsurifoundation@gmail.com

APPLICATION

(Financial aid for treatment of diseases/Eye operations)

1. Name: _____
2. Father's name: _____
3. Age: _____
4. Occupation _____ Monthly income_____
5. Married/Unmarried _____
6. Family size (No. of members)_____
7. Whether income tax payer or not_____
8. PAN No. _____
9. Aadhar No. _____
10. Address: _____
11. Disease: _____
12. Name of Doctor (who is treating): _____
13. Phone number of Doctor:_____
14. Surgery needed or only medicine required:_____
15. Approximate expense:_____

16. List of Medicine needed with quantity

	Name of medicine	Quantity	Amount
(i)	_____	_____	_____
(ii)	_____	_____	_____
(iii)	_____	_____	_____
(iv)	_____	_____	_____
(v)	_____	_____	_____

17. Detail of bank account where financial assistance is to be deposited:

    Name: A/C No:

    Bank: IFSC Code:

18. Duration (Time period) for assistance required (Give Date or no. of months/years)_____

19. Attach three copies of last prescription by Doctor.

Signature