SHREE VISHA DISHAVAL MITRA MANDAL

15 Samarth Complex, Jawahar Nagar Road no.1 opp Bhaji Market,
Goregaon (W) Mumbai

Telephone No.02228767525, EMAIL: svdmmandal@gmail.com,
Website: www.svdm.org

RAJIV JAGDISH SHAH-BALISANA(KOKILABEN AMBANI HOSPITAL) MEDICAL RELIEF SCHEME

REF. NO._____

A. PATIENT'S DETAILS

Please affix your recent passport size photograph & sign across it. (Do not staple)

1.Name of the Patient :_____

2. Parent 's / Spouse Name: _____

3. a. Gender: ☐ Male ☐ Female **b. Marital status:** ☐ Single ☐ Married

c. Date of birth: _____ (dd/mm/yyyy)

4. Native Place: _____

5. a. Name of the Claimant on behalf of Patient: _____

b. Relationship with Patient: _____

6.. a. PAN: _____ **b. Unique Identification Number (UID)/ Aadhaar, if any:**

_____

7. Annual Income (Attach latest Copy of IT Return): Rs._____

(In case of Minor/Non-working family member give details of Head of the Family)

B.ADDRESS DETAILS

1. Permanent Address _____

_____

City/Town/Village: _____ **Pin Code:** _____ **State:** _____

2. Contact Details (with STD): Tel. (Off.) _____ **Tel. (Res.)** _____

Mobile No.: _____ **Email id:** _____

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RAJIV JAGDISH SHAH-BALISANA(KOKILABEN AMBANI HOSPITAL) MEDICAL RELIEF SCHEME

C. REQUIREMENT OF MEDICAL TREATMENT AS UNDER

S.NO.	DISEASE	PUT "√" AGAINST THE DISEASE
1	Angioplasty	
2	By Pass Surgery	
3	Angiography	
4	Cardiopulmonary Rehabilitation	
5	Nuero Surgery and rehabilitation	
6	DBS Surgery for Parkinson and Rehabilitation	
7	Epilepsy Surgery and Rehabilitation	
8	Comprehensive Epilepsy Care Programme	
9	General and Gynecological Oncology Services	
10	Pediatric Surgeries	
11	Vascular Surgeries	
12	Transplant Surgeries	
13	Accident Emergency Cases	
14	Any other life saving emergency cases (Please Specify)	

D. PHYSICIAN/REFERENCE DOCTOR DETAILS

1. **FULL NAME & ADDRESS:** _____

_____

2. **CONTACT DETAILS:** **Tel. (Clinic)** _____ **Tel. (Res.)** _____

Mobile No.: _____ **Email id:** _____

3. **DETAILS OF PATIENT HISTORY:** _____

_____

_____

DECLARATION

I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately.

_____ **Date:- _____**

Signature of the applicant **(dd/mm/yyyy)**

FOR OFFICE USE ONLY

The Application of Mr./Mrs._____having Ref. No._____ is approved in the Special Committee's (of Shree Visha Dishaval Mitra Mandal) Meeting held on _____ . This copy may be produced to the Authorities of Kokilaben Dhirubhai Ambani Hospital and Medical research Institute(Mandake Foundation), Andheri (W), Mumbai-400053 for availing the Medical Relief from the Hospital as per the terms of the MOU vide MOU dt. 2nd February, 2013 entered with the Hospital by the Donor Ms. Sharvari R Shah on behalf of Estate of Rajiv Shah.

_____ **_____**

Signature of the Authorized Signatory **Signature of the Authorized Signatory/Donor**

Date: - _____ **Date: _____**