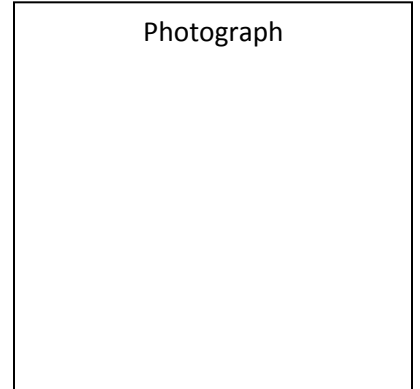


Dardi Sahayak Trust
A/2, Sahajanand Appts., Tarang Society, Vadodara 390 020
Phone: +91 265 2311294

Request for Medical Assistance

Photograph

1) Name of Patient: _____
2) Birth Date & Age: ____ / ____ / _____ & ____ years
3) Father/ Husband's Name: _____
4) Address: _____



5) Contact no: _____
6) Medical Details: _____

7) Hospital / Nursing _____ (Attach Copy of
Home Name & Address: _____ Prescription Letter)

8) Estimated Medical Expenses: _____

9) Medical Expenses already incurred: _____

10) Detail of family _____
Members with _____
present employment _____
status of each _____
member _____

11) Annual income of _____
Family (Member-wise) _____ (Attach documentary proof)

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12) Do you or your family members own any of the following:

- a) Two Wheeler : Yes / No (If Yes, please specify _____)
- b) Four Wheeler : Yes / No (If Yes, please specify _____)
- c) Own House : Yes / No (If Yes, approximate market value _____)
- d) Mobile : Yes / No
- e) Fridge : Yes / No
- f) Television :Yes / No

I _____ confirm that the above mentioned detail is true and correct. Further, I agree to provide such documentary proof as my required by the Verifying Authority for processing my application.

Signature of Applicant

Signature of Parent / Husband

Recommendations of concerned Doctor / Hospital

Signature of Administrator / Doctor
Of Hospital / Nursing Home

Application Accepted / Rejected. Financial Assistance Sanctioned for Rs. _____

Signature of Trustee
Dardi Sahayak Trust