APPLICATION FORM FOR FINANCIAL ASSISTANCE TO NEEDY CANCER PATIENTS

File No. _____ **Amount Last Paid** _____ **Cheque No.** _____ **Date** _____

CANCER AID SOCIETY

NATIONAL OFFICE : 163, Naharpur, Sector 07, Rohini, DELHI - 085., **Ph. : 011 - 27052913**
HEAD OFFICE : 2A, First Floor, Regency Avadh Complex, Chowk, LUCKNOW - 03., **Ph. : 0522 - 2259157**
REGIONAL OFFICES **Fax : 0522 - 2259239**
MUMBAI : A-6, Flat No. 2, RNA Broadway Avenue, Meera Road (East),Thane, MUMBAI. Ph. 022 - 28121794
CHENNAI : Flat No. 1, RR Flats, 5 Anthu Street, Santhome, CHENNAI.
KOLKATA : First Floor, Property No. 23, Baluhakkak Lane, Near Park Circus Market. KOLKATA
AHMEDABAD : 9 Tulsi Aptt, Opp. Central Bank of India, Ambavadi Circle, Ahmedabad

1. Name of Patient _____
2. Father / Husband _____
3. Present Address _____
   _____
   _____ **Ph.** _____
4. Permanent Address _____
   _____
   _____ **Ph.** _____

Attested Photograph

	Sl. No.	Name	Occupation	Income
Name of Patient				
Details of Dependents	1. 2. 3. 4.			

4a) Place of Treatment _____ City _____ State _____

b) Name of Treating Doctor _____ Qualifications _____

5. Approximate Monthly Expenditure Certified by the Doctor _____

6. Amount of Aid Applied for _____

7 a) Aid Received Earlier **: YES / NO** b) If **YES**, give the Name of the Organisation with amount _____

Declaration : The above mentioned details are TRUE to the best of my knowledge. In the event of any false statement I am ready to abide by the decision of the Society whatever it may be.

_____ _____ _____

Signature / Thumb Impression **Date** **Place**

Certified / Recommended by School Principal _____ **Signature / Seal** _____ **dated :**

NOTE : Following Documents are to be submitted with the application.

Serial No. [A]

a) Proof showing that the patient is suffering from Cancer.
b) One Photograph of the patient.
c) Proof showing that the patient cannot afford the treatment.
d) A note from the treating Cancer Specialist Doctor showing the approximate expenditure in treatment to be incurred in the coming month.
e) Authority Letter, in case the cheque should be handed over to an authorised person/relative.
f) Photocopy of the Form (one in no.)

FOR OFFICE USE ONLY

File No. _____ **Name of Patient** _____ 1. **Sanctioned / Not Sanctioned**

2. If payment is made by A/c Payee Cheque. **Cheque No.** _____ **Date** _____ **A mount** _____

3. Cheque given by hand / sent by Registered Post **Details : Number** **Date**