PHOTO

CANCER PATIENT'S AID SOCIETY

REGISTERED OFFICE: B-606, MANSI PLAZA, I.C.COLONY, BORIVALI (W), MUMBAI – 400103

PHONE: 022-28964179, E-MAIL: info@cpaids.org, WEB SITE: www.cpaids.org

PALGHAR OFFICE: FLAT NO.8, PARK AVENUE, PALGHAR (E) - 401 404

PATIENT'S NAME :……

FATHER'S /MOTHER'S/HUSBAND'S NAME :……

PERMANENT ADDRESS :……

……

ADDRESS FOR COMMUNICATION : ……

……

PHONE NO. : (1) …… (2) ……

FAMILY DETAILS

Sr	NAME	AGE	MONTHLY INCOME	RELATION	PHONE NO.	OTHER INFORMATION
1.						
2.						
3.						
4.						
5						
6.						

HOSPITAL & FINANCIAL HELP DETAILS

Sr.	HOSPITAL'S NAME	NAME OF DOCTOR	**Sr**.	NAME OF ORGANISTAION	AMOUNT	CONTACT PERSON & PHONE
1			1			
2			2			
3			3			

TO,

THE SECRETARY/DIRECTOR,
CANCER PATIENT'S AID SOCIETY,
B-606, MANSI PLAZA, I.C.COLONY,
BORIVALI (W), MUMBAI-400103.

DATE:

RE: FINANCIAL SUPPORT/REIMBURSEMENT OF MEDICAL EXPENSES FOR DIET & NUTRITION NEED OF CANCER PATIENT MR./MS./MRS.…… S/D/H/W/B OF MR./MRS./MS…….....
& UPLOADING OF PICTURE AND DETAILS OF PATIENT AT ITS WEBSITE FOR APPEAL TO DONATION FROM PUBLIC AT LARGE.

RESPECTED SIR/MADAM,

MAY PLEASE PERUSE THE ATTACHED APPLICATION OF MR. /MS. /MRS. …… A CANCER PATIENT, WHO IS UNDERGOING TREATMENT AT …….. SINCE LAST …… MONTHS/YEARS.

SINCE THEN A HUGE MONEY HAVE BEEN SPENT ON TREATMENT /LODGING & BOARDING BUT NO REGULAR SOURCE OF INCOME DUE TO LEAVING OF MY JOB/BUSINESS FOR STAYING WITH PATIENT , HENCE ACUTE URGENCY OF FINANCIAL SUPPORT IS NEEDED.

THEREFORE MAY I REQUEST YOU TO PLEASE REIMBURSE MEDICAL EXPENSES OR EXTEND SOME FINANCIAL SUPPORT SO THAT PATIENT CAN BE GIVEN GOOD HYGIENIC DIET & REGULAR PROTEINS /FRUITS TO ENHANCE HIS/HER IMMUNITY TO COPE UP WITH HIGH DOSE OF CHEMOTHERAPY, AS ADVISED BY THE TREATING DOCTOR & FAST COME BACK TO NORMAL LIFE.

I DO HEREBY CONSENT & AGREE TO ALLOW SOCIETY TO UPLOAD THE PICTURE & MEDICAL DETAILS ALONG WITH ADDRESS OF CANCER PATIENT & OURS AT THE WEB-SITE OF SOCIETY, CANCER PATIENT'S AID SOCIETY, TO SOLICIT FINANCIAL DONATIONS/NUTRITION /OTHER HELP FOR THE PATIENT FROM PUBLIC AT LARGE.

DECLERATION

I,……S/D/W……HEREBY DECLEARE THAT INFORMATION SUBMITTED AFORSAID ARE TRUE & FAIRTO THE BEST OF MY KNOWLEDGE & BELIEF. IF ANY INFORMATION SUBMITTED AFORSAID FOUND INCORRECT/HIDDEN/UNFAIR SUITABLE ACTION UNDER THE LAW WOULD BE TAKEN AGAINST ME & MY LEGAL HEIRS & ALL COST /FINANCIAL AID PROVIDED WOULD BE RETURNED BACK TO CANCER PATIENT'S AID SOCIETY ALONGWITH LEGAL COST, IF ANY.

PLACE: DATE: (MR. /MRS. ……)

DOCUMENTS TO BE ATTACHED (XEROX COPIES SELF ATTESTED)

1. INCOME PROOF (IN CASE OF MINOR FATHER/GUARDIAN)
2. ADDRESS PROOF (RATION/ADHAR/PASSPORT OR D/L)
3. HOSPITALS COST CERTIFICATE.
4. TWO SELF-ATTESTADE PHOTOGRAPH OF PATIENT.
5. LATEST TEST & DIAGNOSIS REPORT.
6. ORIGINAL BILLS ALREADY PAID/PAYABLE.

FOR OFFICE USE ONLY

RECOMMENDED /REJECTED FOR RS. …… (RS……)CHECK NO…….

DATE……..AMOUNT……..BANK & BRANCH…….

SENT BYCOURIER/SPEEC POST/HAND DELEVERY.NO……..DATE……..

RECEIPTANT'S SIGNATURE

(MR. /MRS……)