अन्तर्राष्ट्रीय वैश्य महासम्मेलन®

International Vaish Federation

Connecting Vaish world over ..... For community Empowerment

H.O.: 516, DLF, Star Tower, Sector-30, Gurugram, Haryana-122001
Website : www.vaishivf.com • **Facebook :** www.facebook.com/VaishIVF
Mob.: 9770010101 **E-mail :** info@vaishivf.com

स्व. रामदास अग्रवाल जी
संस्थापक अध्यक्ष

APPLICATION FORM FOR IVF RELIEF FUND IN THE CATEGORY OF "HEALTH"

Request for Grant in Rs.: .....

1. Name of the Patient : _____
2. Contact Details of the Patient : Mob. _____ E-mail _____
3. Date of Birth of the Patient : _____ Aadhar No. _____
4. Name of the Applicant (Family Member Only) _____
5. Contact Details of the Applicant : Mob. _____ E-mail _____
6. Applicant Relationship with the Patient : _____
7. Complete Postal Address of the Patient : _____

   City / Town : _____

   District : _____

   State : _____ Pin _____
8. Cast : _____ Gotra _____
9. Family Income including of Patient :

Name	Relationship with Patient	Occupation	Annual Income
1. Patient	Self		

10. Details of Decease / Illness : _____

_____

11. Details of Mediclaim Policy / Ayushman Card :

Policy No.: _____

Policy Amount : _____

Any Other Information : _____

12. Hospital's Details :

Name of the Hospital _____

Total No. of Beds in the Hospital _____

Address of the Hospital _____

_____

Hospital Website _____

Hospital's Contact No. (Landline) _____ E-mail : _____

Hospital Account Details :

Account No. _____

Name of the Bank _____

Branch Address _____

_____

IFSC Code _____

Name of the Doctor _____ Mob.: _____

Estimate Expenses / Bill from the Hospital _____

Note : Please attach your Prescription & Estimate / Bill from the Hospital

If you want to write something :

DECLARATION

I declare that the above details and information provided by me are true to the best of my knowledge and belief. I do solemnly confirm and declare to adhere this policy of one assistance only and will not violate knowingly or unknowingly this terms . If any grant received by me from any other place for the same cause, then I will refund the excess grant immediately.

Date _____ Patient Sign. _____ Applicant Sign. _____

Place _____ Patient Name _____ Applicant Name _____

DETAILS OF REFERENCER 1.

Name : _____

Mob. _____

E-mail : _____

Address : _____

_____

_____

Signature : _____

DETAILS OF REFERENCER 2.

Name : _____

Mob.: _____

E-mail : _____

Address : _____

_____

_____

Signature : _____

TERMS AND CONDITIONS :

1. Please be informed that only those candidates are eligible for the Financial Assistance in the Category of "HEALTH" whose belonging to needy / economically weaker section of Community (The Total Income of Self & Parents etc. from all sources should be less than Rs. 3 Lakhs Per Annum) only.
2. IVF reserves the right for final sanction of the grant.
3. IVF decision made by empowered committee can not the challenged.
4. Applications to be sent by E-mail : info@vaishivf.com and to be followed hard copy by post at International Vaish Federation's Head Office.: 516, DLF Star Tower, Sector-30, Gurugram, Haryana-122001, Mob.: 9770010101.
5. Total No. of Beds in the Hospital preferably more than 5 beds at Tehsil level and more than 25 beds at District & above level.

NOTE : Please submit these documents :

- Copy of the Aadhar Card of Patient
- Income Proof of the Family
- Estimate of the expenses from the Hospital