

# Application form for Assam Arogya Nidhi

1. Name of the Patient (in Block Letters) .....
2. Age .....
3. (A) Permanent Address .....
- .....
- (B) Address for Correspondence .....
- .....
4. Father's Name .....
5. Gender .....
6. Category (Gen/ST/SC/OBC) .....
6. Name of the Applicant if the .....  
Application is not made by the  
Patient.
7. Application's Relationship to the .....  
Patient
8. Disease for which Treatment is .....  
Required
9. Name of Hospital where the .....  
Treatment is being Received.
10. Income of the Patient/Parent, duly .....  
certified by the Deputy Commissioner/.....  
Sub-divisional Officer (Civil)/ Block .....

Development Officer certifying that .....  
the beneficiary has a monthly income .....  
less than Rs 10,000. ....

11. Amount of one-time financial .....  
Assistance required.

12. Whether Financial Assistance for the .....  
same purpose has been received .....  
from any other government deptt. ....  
other than the NRHM, if so, give detail .....

**DECLARATION**

I declare that the information given above is correct and complete in all respects and that I am in no position at all to arrange for /provide funds for the purpose stated above.

Dated:

Signature of the Applicant/Patient.

**To be filled by the Hospital where the patient is receiving the treatment**

1. Name and address of the Hospital .....

2. Patient's Name & Hospital .....

Registration Number

3. List of Important Medical Report .....

(reports to be attested and enclosed)

4. Diagnosis: (A Short note on .....

the present clinical condition) .....

.....

5. The Amount of Money Recommended .....

6. Item wise Break-up of Expenditure .....

of Amount Recommended at Col.No.5. ....

7. Name and Cost of the Consumables/ .....

Medicines Required for Operation/ .....

Treatment (Cost in Rupees)

Signature of the treating doctor

Signature of the Head of the  
Department with Official Seal

Signature of the Chief Medical  
Officer/Superintendent with Official Seal