SAHACHARI RELIEF CELL

SKSSF STATE COMMITTEE

Islamic Centre, Kozhikode - 2. Ph: 0495 - 2700177

APPLICATION FORM

Name of Applicant

Sl. No.

Address

Phone

Unit Registration No.

Unit	Mahallu	Cluster	Zone	District

Relation with Organisation

Membership No. if the patiant is an SKSSF member

Nearest Sahachari Centre

Ilness	Oldness of Illness	Hospital Consulted

Other information

Economic Status	Income source	Annual Income

Family Members	Occupation	Age

DECLARATION

I Hereby declare that all the above cited details are true to my knwoledge and I there for, request to kindly sanction relief from Sahachari Cell.

Name of Applicant & Signature

(P.T.O)

Releif will be credited to the bank account of the Patient or those who are entrusted by the patient.

Name and phone Number of Patient or the Person entrusted by the patient	

Account No.		Bank	
Branch		IFSC	

Name of Unit Secretary:

Phone Number: Membership No:

Complete Address:

Signature :

Name of District General Secretary:

Phone: Date: / / Signature:

Name of Sahachari Centre Co-ordinator:

Phone: Signature:

Brief report of the Doctor Consulted

Name of Doctor, Signature & Seal

for Office Use only

Meeting Decision

- ☐ Cancer
- ☐ Cardiac
- ☐ Dialisis
- ☐ Kidny Transplantation
- ☐ Others

General Convenor:

Amount in words. .....

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Office Procedures

Voucher No.	Date:	Amount

Office Secretary:

Name:

Signature: