Student-Led Initiative for Childhood Blood Cancer Treatment

Page 1: Patient & Family Declaration Form

Patient Details:

- Full Name: _____
- Age: _____Gender: _____
- Aadhaar Number: _____
- Diagnosis: _____
- Treatment Required: _____
- Address: _____

_____

Guardian/Parent Details:

- Full Name: _____
- Relation to Patient: _____
- Phone Number: _____
- Alternate Contact Number: _____

Declaration by the Guardian / Parent:

I, the undersigned, declare that:

1. The patient mentioned above is currently undergoing treatment for a critical illness and is in urgent need of financial assistance.
2. I confirm that all the information provided is true and supported by valid documents.
3. I understand that any financial assistance received will be directly paid to the treating hospital, not to the family or individual.
4. I agree to cooperate in submitting all required documents for verification.
5. I take full responsibility for the authenticity of this request.

Signature of Guardian/Parent: _____

Date: _____

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Page 2: Treating Doctor / Hospital Declaration

To be filled and signed by the treating physician and verified by the hospital authority.

Hospital Name: _____

Hospital Address: _____

Phone Number: _____

Email ID (if any): _____

Patient Details (As per Hospital Record):

- Patient Name: _____
- Age / Gender: _____
- Patient Hospital ID (if any): _____
- Diagnosis: _____
- Current Treatment Plan: _____
- Estimated Cost of Treatment: _____

Declaration by the Treating Doctor:

I, Dr. _____, hereby declare that:

1. The above-named patient is under my treatment and is being treated for a serious medical condition.
2. The medical and cost details provided above are accurate.
3. The patient/family has requested financial assistance.
4. We confirm that any approved donation will be accepted only in the name of the hospital for the patient's treatment.

Signature of Doctor: _____

Doctors Registration No.: _____

Date: _____

Hospital Seal & Signature (Admin): _____

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Page 3: Police Verification Declaration

To be filled by the local Police Station of the patients residential address

Police Station Name: _____

Address: _____

Officer Name: _____

Designation: _____

Phone Number: _____

Declaration by the Police Officer:

I confirm that:

1. I have verified the background of the above-mentioned patient and their family.

2. To the best of our knowledge, there is no criminal background or misuse record related to medical fraud by the applicant.

3. This verification is being issued only for the purpose of confirming the legitimacy of the claim.

Signature of Officer: _____

Official Stamp: _____

Date: _____

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Page 4: Terms & Conditions

Student-Led Initiative Declaration Legal Terms & Compliance

1. All donations will be directly transferred to the hospitals authorized account only.
2. No amount will be given in cash or to individuals under any circumstances.
3. The initiative reserves the right to verify submitted documents and reject applications with incomplete or false information.
4. If any suspicious, fraudulent, or misleading information is found during or after the review:
   - The application will be rejected or canceled immediately.
   - Legal action may be taken against the applicant and hospital involved (if applicable).
5. Hospital cooperation is mandatory for fund release.
6. All decisions made by the Student-Led Initiative panel are final.

Acknowledgement by Guardian:

I have read and understood the above terms and conditions and agree to abide by them.

Signature (Guardian): _____

Date: _____