

Form No.:



## Request for Medical Assistive Devices Provision or Financial Aid for Medical Assistive Devices



\*\* This form should only be filled if the financial aid required is for a machine that is necessary for the patient to remedy a life threatening situation or to safeguard against a permanent disability. \*\*

### 1 - Patient's Details

1.1 - Name:

1.2 - NID No.:

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### 2 - Details of the Machine / Device

2.1 - Machine / Device Name:

2.2 - Vendor's Name:

2.3 - Quotation No.:

### 3 - Doctor's Recommendation

I hereby recommend the foregoing machine / device for the above-mentioned patient's recommended treatment.

3.1 - Further Justification (If Required):

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3.2 - Doctor's Name:

3.3 - Stamp & Signature:

3.4 - Date:

D	D	M	M	Y	Y	Y	Y
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### 4 - Patient's Declaration

I hereby agree to use any aid provided solely for the purpose mentioned on this application. If the aid granted is financial, I agree to submit the receipt within 30 days of the purchase of the machine to Aasandha and to return any remaining balance to Aasandha. If I am found in violation of the above, Aasandha has the right to reject any future applications.

4.1 - Name:

4.2 - NID No.:

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4.3 - Patient's Signature:

4.4 - Date:

D	D	M	M	Y	Y	Y	Y
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