(Photograph of the patient)

Authorisation for Treatment Aided by BVMT

NAME OF THE PATIENT	
AGE / SEX OF THE PATIENT	
MRD NUMBER	
DATE OF ADMISSION	
TREATING CONSULTANT	
SPECIALITY	
DIAGNOSIS	
TREATMENT PLANNED (Summary to be Attached)	
ADDRESS OF THE PATIENT	
DOCUMENTS ATTACHED	
Copy of Income Certificate /BPL Card/Salary Slip **Copy of Aadhar Card/Voter I Card /PAN Card**	☐ **Number** _____ ☐ **Number** _____
ESTIMATED COST OF THE TREATMENT /PROCEDURE	
AMOUNT OF AID APPROVED BY BVMT	
APPROVAL AUTHORITY BANSIVIDYA MEMORIAL TRUST (Name & Signature)	