স্বাস্থ্য ও পরিবার কল্যাণ দপ্তর, পশ্চিমবঙ্গ সরকার



Swasthya Sathi Swasthya Bhawan GN-29, Sec-V, Salt Lake, Bidhan Nagar, Kolkata-91, West Bengal

FORM-A (Application for name addition under Swasthya Sathi)

| | | Application | NO: | | | | | | |]/[| |
|---|---|----------------|------------|-----------|-----------------|---|-----------------|--------------|------------|-------------------------|--|
| | DATE | | | | | | | | DATE | | |
| | BLOCK/MUNICIPALITY:- PANCHAYAT :- NAME OF THE BENEFICIARY: | | | | | | | | | | |
| | GE/WARD:- | | | | | | | | | | |
| RESI | RESIDENTIAL ADDRESS:- FATHER'S NAME: | | | | | | | | | | |
| | | | | | | | | | | | |
| | DO ANY MEMBER OF THE FAMILY RECEIVE GOVT. | | | | | | | | | | |
| | SPONSORED HEALTH INSURANCE / ASSURANCE : YES / NO DO ANY MEMBER OF THE FAMILY RECEIVE MEDICAL | | | | | | | | | | |
| LIDN | NUMBER :- | | | | | THE RESERVE OF THE PROPERTY OF THE PARTY OF | 0.55.00.000.000 | E PAMILY REG | SEIVE MEDI | YES / NO | |
| UNIN | | | | | | | \neg | | 7 | | |
| | | | | | | | | | | | |
| | | | -NAME | S TO | BE AD | DED- | | - 16 | | | |
| SL NO | MEMBER NAME | SEX AG | E RELAT | TION | МОВІІ | LE NO, | KHA | DYASATH | I ID NO. | AADHAAR NO. (If Any) | |
| 1 | | | | | | | | | | | |
| 2 | | | | | | | | | | | |
| 3 | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| .5 | | | | | | | | | | | |
| 6 | | | | | | | | | | | |
| 7 | | | | | | | | | | | |
| 8 | | | | | | | | | | | |
| 9 | | | | | | | | | | | |
| 10 | | | | | | | | | | | |
| | | পত্নিবারের সেই | ই সকল সদকে | ার নাম বি | - লখুন যাদের | নাম অন্ত | ক্তি করতে | হবে | | | |
| উপরোক্ত তথা সম্পূর্ণ সভা এবং আমার পরিবারের উপরোক্ত স্বদস্যগণের নাম ইতিপূর্বে স্বাস্থ্য সাধী কার্ডে নথিভুক্ত হয়নি | | | | | | | | | | | |
| SIGNATURE OF VERIFYING OFFICER | | | | | | | | | | | |
| NAME: | | | | | | | | | | | |
| বিশদে জানতে ১৮০০-৩৪৫-৫৩৮৪ নমরে যোগাযোগ করতে পারেন। স্বাস্থ্য ও পরিবার কল্যাণ দপ্তর, পশ্চিমবঙ্গ সরকার সর্বদাই আপনার পাশে আছে। | | | | | | | | | | | |
| | | | | | | | | | | | |
| Received Swasthya Sathi Application from | | | | | | | | | | | |
| Арр | Application NO: DATE Signature | | | | | | | | | | |

স্বাস্থ্য ও পরিবার কল্যাণ দপ্তর, পশ্চিমবঙ্গ সরকার



Swasthya Sathi Swasthya Bhawan GN-29, Sec-V, Salt Lake, Bidhan Nagar, Kolkata-91, West Bengal

FORM-B (Application for enrollment under Swasthya Sathi)

| | | | | | | Trial | FOS | | | | | |
|---|----------------------------|-----------|------------|----------------------|--|--|---|--|--|--|--|--|
| | | | | Applicat | ion NO : | | | | | | | |
| DISTR | ICT : | | | | CAMP NAME SERIAL NO DATE | | | | | | | |
| | C/MUNICIPALITY:- | | | | MINORIT | MINORITY STATUS: YES/NO | | | | | | |
| | HAYAT :- | | | | CASTE : SC/ ST/ OBC | | | | | | | |
| | GE/WARD:- | | | | DEPARTMENT (IF EMPLOYED) : | | | | | | | |
| KESIL | DENTIAL ADDRESS:- | | | | CATEGORY: | | | | | | | |
| | | | | | NAME OF 1 | THE APPLICANT : | | | | | | |
| OFFICE NAME & ADDRESS: (IF APPLICANT OR MEMBER IS EMPLOYED) FATHER'S NAME: | | | | | | | | | | | | |
| | | | | | DO ANY MEMB | ER OF THE FAMILY RECEIVE GOVT. | | | | | | |
| 1 | | | | | ELEVATION FAMILIANS | HEALTH INSURANCE / ASSURANCE | | | | | | |
| 1 | | | | | | ER OF THE FAMILY RECEIVE MEDIC FROM GOVERNMENT : | CAL YES / NO | | | | | |
| | | 10 0 | | | | | TES / NO | | | | | |
| SL NO | MEMBER NAME | SEX | AGE | RELATION | MOBILE NO. | KHADYASATHI ID NO. | AADHAAR NO. (If Any) | | | | | |
| 1 | | | | Beneficiary /Self | | | | | | | | |
| 2 | | | (8) | | | | | | | | | |
| 3 | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |
| 7 | | | | | 1 | | , | | | | | |
| 8 | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | |
| | | | | পরিবারের সকল ২ | ন্দস্যের নাম লিখুন | | | | | | | |
| SIGN NAME:_ | ATURE OF VERIFYING OFFICER | ÷c | | | | উপরোক্ত তথ্য সম্পূর্ণ সত্য এবং কোন সদস্য ইতিপূর্বে স্বাস্থ্যসাথী কাড এর BENEFICIARY S | র্ট পাইনি বা স্বাস্থ্যসাথী কার্ড জন্য ফর্ম-B দাখিল করিনি। | | | | | |
| | | | | | র যোগাযোগ করতে কার সর্বদাই আ | *GP-074554 (De 1944 0*) 1946 (De 1944 0*) | en en en el en en en en el esta en en el esta en en el esta en en el esta en en el en el en en el en en el en | | | | | |
| Rece | ived Swasthya Sath | i Applica | ation f | rom | ************* | | ***************** | | | | | |
| | 1 | | <i>,</i> — | | | | | | | | | |
| Application No : Signature Signature | | | | | | | | | | | | |

স্বাস্থ্য ও পরিবার কল্যাণ দপ্তর, পশ্চিমবঙ্গ সরকার



Swasthya Sathi Swasthya Bhawan GN-29, Sec-V, Salt Lake, Bidhan Nagar, Kolkata-91, West Bengal

FORM-C (Application for name correction under Swasthya Sathi)

| | <u>T</u> | URIVI-C IA | pplicatio | ni ioi nam | ecc | nection | unuer | wasi | iiya 3 | atinj | | | |
|---|--|---------------|-----------|----------------------|------|-------------|-----------|-----------------|--------------------------|--------|----------|-------|--|
| DISTR | DICT · | Applicati | on NO | : | | | | | | | | | /[|
| | | 8 | | | | | | | | | | | DATE |
| 5 4 2 5 5 5 5 5 5 | BLOCK/MUNICIPALITY:- PANCHAYAT :- NAME OF THE BENEFICIARY : | | | | | | | | | | 1 | | |
| PANCHAYAT :- NAME OF THE BENEFICIARY : VILLAGE/WARD:- | | | | | | | | | | | | | |
| The second second second | DENTIAL ADDRESS:- | | | | | | | | | | | | |
| KESI | DENTIAL ADDRESS: | • | | | 1 | F | ATHER'S | NAME | | | | | |
| | | | | | | | | | | | | | |
| | | | | | l | | | | | | RECEIVE | | |
| | | | | | l | SPC | NSORED | HEALT | H INSU | RANCE | / ASSUR/ | ANCE | YES / NO |
| | | | | | | DO | ANY MEM | BER OF | THE F | AMILY | RECEIVE | MEDIC | CAL |
| URN | NUMBER :- | | | | - | ALL | OWANCE | FROM | GOVER | RNMENT | r: | | YES / NO |
| | | | | | | | | | | | | | |
| 1 | | | 1 1 | | | | | | | | - 1 | | |
| <u> </u> | | | | | | | | | | | | | |
| l. | CONTROL DEGLES CARRESTON CONTROL | | | MES TO | _ | | | - | A Property of the second | | | 11000 | September 19 Common Process Common September 19 Common September 1 |
| SL NO | EXISTING NAME | SEX | AGE | RELATION | | MOBIL | E NO. | K | HAD | YASA' | THI ID | NO. | AADHAAR NO. (If Any) |
| 1 | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| 3 | | | | | | | | \perp | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | |
| | 9 | রিবারের সেই স | কল সদসে | ার নাম লিখুন | যার | দর নাম অং | বা তথ্য স | নহ েশা ধ | ন কর | তে হৰে | r | | |
| SIGNATURE OF VERIFYING OFFICER BENEFICIARY SIGNATURE | | | | | | | | | | | | | |
| NAME: | | | | | | | | | | | | | |
| | ਰਿ* | াদে জানতে ১৷ | TOO-198 | ስ- <i>(</i> ስላ) አል ፣ | स्र | ব যোগাযো | গ কবন | ত পা7 | বন ৷ | | | | |
| | স্বাস্থ্য ও পরিবার | | | | | | | | | ान्ध | আছে | ĺ | |
| | | | | | •••• | *********** | | | | | | | |
| Rece | eived Swasthya Sa | ithi Applica | tion fro | m | | | | | | | | | |
| Appli | ication NO: | | | | | | 7/[| | | - | | Sia | nature |

স্বাস্থ্য ও পরিবার কল্যাণ দপ্তর, পশ্চিমবঙ্গ সরকার



Swasthya Sathi Swasthya Bhawan GN-29, Sec-V, Salt Lake, Bidhan Nagar, Kolkata-91, West Bengal

FORM-D (Application for name deletion under Swasthya Sathi)

| | | Application | NO: | | | $\Box / \Box \Box$ | | | | | |
|---|---|-------------|----------------|-----------------------|--------------------|-------------------------|--|--|--|--|--|
| DISTR | RICT : K/MUNICIPALITY:- | *0 | | | | DATE | | | | | |
| | CHAYAT :- | | | NAME OF T | HE BENEFICIARY : | | | | | | |
| VILLAGE/WARD:- | | | | | | | | | | | |
| RESIDENTIAL ADDRESS:- FATHER'S NAME : | | | | | | | | | | | |
| | DO ANY MEMBER OF THE FAMILY RECEIVE GOVT. | | | | | | | | | | |
| SPONSORED HEALTH INSURANCE / ASSURANCE : YES / NO | | | | | | | | | | | |
| DO ANY MEMBER OF THE FAMILY RECEIVE MEDICAL ALLOWANCE FROM GOVERNMENT: YES / NO | | | | | | | | | | | |
| UKN | NUMBER :- | | | | | [120]/[110] | | | | | |
| | | | | | | | | | | | |
| • | | | NAMES TO | BE DELETED | | | | | | | |
| SL NO | EXISTING NAME | SEX AGE | RELATION | MOBILE NO. | KHADYASATHI ID NO. | AADHAAR NO. (If Any) | | | | | |
| 1 | | | | | | | | | | | |
| 2 | | | | | | | | | | | |
| 3 | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| 5 | | | | | = | | | | | | |
| 6 | | | | | | | | | | | |
| 7 | | | | | | | | | | | |
| 8 | | | | | | | | | | | |
| 9 | | | | | | | | | | | |
| 10 | | | | | | | | | | | |
| | | পরিবারের সে | ই সকল সদসোর না | ম লিখুন থালের নাম বাদ | দিতে হবে | | | | | | |
| SIGNATURE OF VERIFYING OFFICER BENEFICIARY SIGNATURE NAME: | | | | | | | | | | | |
| বিশদে জানতে ১৮০০-৩৪৫-৫৩৮৪ নম্বরে যোগাযোগ করতে পারেন। স্বাস্থ্য ও পরিবার কল্যাণ দপ্তর, পশ্চিমবঙ্গ সরকার সর্বদাই আপনার পাশে আছে। | | | | | | | | | | | |
| Received Swasthya Sathi Application from | | | | | | | | | | | |
| Appl | ication NO: | | | /L | Sig | nature | | | | | |
| | - | | | D. | ATE | | | | | | |