Reference (provide one reference other than family members)

Name: _____

CNIC #: _____

Occupation and Organization: _____

Contact Number: _____

Relation with Patient: _____

Sign: _____

Affidavit

- I declare that information provided above is correct to the best of my knowledge.
- I understand that hospital has the right to terminate my request for financial assistance if any misleading/incorrect information found.
- If partial financial assistance is approved, I am responsible for paying my share (10% to 50%) of the total bill amount in advance.

Name of Patient

_____

CNIC #

_____

Sign

_____

Date

_____

Name of Guardian

_____

CNIC #

_____

Sign

_____

Date

_____