



Patient Application for Membership

Please provide us with the following information, which will be treated in strict confidence. There is **no membership fee** for ALS patients, who are Life Members of the ALS Society of BC.

TODAY'S DATE: _____ DIAGNOSIS DATE: _____

SURNAME: _____ **FIRST NAME:** _____

_____ MALE _____ FEMALE DATE OF BIRTH: _____

SPOUSE'S NAME: _____

STREET ADDRESS: _____

CITY: _____ PROV: _____ POSTAL CODE: _____

PHONE (H): _____ (W): _____

FAX: _____ EMAIL: _____

PRIMARY CAREGIVER: _____

(IF DIFFERENT FROM SPOUSE)

RELATIONSHIP: _____

STREET ADDRESS: _____

CITY/PROVINCE: _____ POSTAL CODE: _____

PH (H): _____ (W): _____

FAX: _____ EMAIL: _____

NEXT OF KIN OR OTHER FAMILY MEMBERS:

NAME: _____ RELATIONSHIP: _____

STREET ADDRESS: _____

CITY/PROVINCE: _____ POSTAL CODE: _____

PHONE (H): _____ (W): _____

FAX: _____ EMAIL: _____

NAME: _____ RELATIONSHIP: _____

STREET ADDRESS: _____

CITY/PROVINCE: _____ POSTAL CODE: _____

PHONE (H): _____ (W): _____

FAX: _____ EMAIL: _____

FAMILY PHYSICIAN: _____ PHONE: _____

NEUROLOGIST: _____ PHONE: _____

NEUROLOGIST: _____ PHONE: _____

Do you or your family have medical coverage beyond the basic provincial plan, eg. extended benefits? Yes No

If yes, please indicate which company, type of plan and contract number:

BC CARE CARD #: _____

Do you have benefits with Veterans Affairs Canada, provincial social programs or other groups?

Yes No If yes, please specify: _____

How were you made aware of the ALS Society of BC? _____

If you would like to receive more information, please check the list below:

- ALS Society of BC Newsletter
- One-on-one communication with other ALS Patients & Families
- Visits by Volunteers

Support Group Meetings, Patients and Caregivers Together

- Please email me information
- Please mail me monthly updates on meetings
- Caregivers Day information (for Caregivers only)

Application for Friends &/Or Family Membership(s)

Please check where appropriate:

- A Family 1 year membership (\$40 enclosed)
- An Individual/Spousal 1 year membership. (\$25 enclosed)
- I would like to receive information on volunteer opportunities at the ALS Society of BC.

I enclose my donation of \$ _____

Please allocate it to the ALS Society of BC:

- Wherever the Need is Greatest
- Patient Services – Equipment Loan Program
- Patient Services – Patient Support
- Patient Services – Reference Library
- Patient Services – Caregivers Day
- Research
- Public Awareness

Please send donation receipt(s) to:

NAME: _____

ADDRESS: _____ CITY: _____

POSTAL CODE: _____ PHONE: _____

FOR ADMINISTRATIVE PURPOSES ONLY – DO NOT WRITE BELOW THIS LINE

M PKG SENT: _____

NP LIST

S. NOTIF.

SGL NOTIF.

Raiser's Edge ENTERED