



AMYOTROPHIC LATERAL SCLEROSIS SOCIETY OF BRITISH COLUMBIA & YUKON

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: _____

RELATIONSHIP: _____

STREET ADDRESS: _____

CITY/PROV: _____ POSTAL CODE: _____

PHONE (H): _____ (W): _____

FAX: _____ EMAIL: _____

NEXT OF KIN OR OTHER FAMILY MEMBERS:

NAME: _____ RELATIONSHIP: _____

STREET ADDRESS: _____

CITY/PROV: _____ POSTAL CODE: _____

PHONE (H): _____ EMAIL: _____

NAME: _____ RELATIONSHIP: _____

STREET ADDRESS: _____

CITY/PROV: _____ POSTAL CODE: _____

PHONE (H): _____ EMAIL: _____



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Patient Application for Membership – page 2

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 (Ministry) 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 communications with other ALS Patients & Families

_____ Visits by Volunteers

_____ ALS411 booklets for Children and Teens

Support Group Meetings, Patients and Caregivers Together:

_____ Please email me information

_____ Please mail me monthly updates on meetings

_____ Caregivers Day information in September (for Caregivers only)



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Application for Friends &/Or Family Membership(s)

Please check where appropriate: (NO fee for patient memberships)

- 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: _____