# REGISTRATION FORM

Muscular Dystrophy Canada

1-866-687-2538
www.muscle.ca

Muscular Dystrophy Canada's mission is to enhance the lives of those affected with neuromuscular disorders by continually working to provide ongoing support and resources while relentlessly searching for a cure through well-funded research. Muscular Dystrophy Canada provides registered clients with a range of services, including support, information, education, advocacy and equipment.

To register, you must have a confirmed diagnosis of a neuromuscular disorder under the Muscular Dystrophy Canada umbrella, and be a Canadian citizen, landed immigrant, or refugee resident in Canada.

Muscular Dystrophy Canada respects your privacy and will keep your personal information confidential. The information on this form has been collected in order to help Muscular Dystrophy Canada provide services that meet your needs, and communicate with you about Muscular Dystrophy Canada's activities and programs. Upon registration, all new clients will receive a Welcome Package and will be contacted by a Muscular Dystrophy Canada representative.

For more information about our privacy policy or Muscular Dystrophy Canada, please call 1 866-687-2538 or visit www.muscle.ca.

## APPLICANT INFORMATION: (TO BE COMPLETED BY APPLICANT/PARENT/GUARDIAN)

**PLEASE PRINT**

Preferred Language: ❑ English ❑ French

Salutation: ❑ Mr. ❑ Mrs. ❑ Ms ❑ Miss ❑ Other: _____ Gender: ❑ Male ❑ Female

Applicant Name: _____ (First) _____ (Initials) _____ (Last) Date of Birth: _____ (Year) _____ (Month) _____ (Day)

Home Address: _____ (Suite# / Street # / Street Name) _____ (City) _____ (Prov) _____ (Postal Code)

Mailing Address: _____ (Suite# / Street # / Street Name) _____ (City) _____ (Prov) _____ (Postal Code)

Telephone: (_____) _____ (Residence) (_____) _____ (Business) (_____) _____ (Cell)

Email: _____

Status: ❑ Canadian Citizen ❑ Landed Immigrant ❑ Refugee Resident ❑ Other _____

How did you hear about Muscular Dystrophy Canada?
❑ Neuromuscular Clinic ❑ Internet ❑ Caregiver
❑ Healthcare Practitioner ❑ Word of Mouth ❑ Family Member
❑ Other: _____

SIGNATURE: _____ (Applicant or Parent / Guardian (if application is under 18 years old)) Date: _____ (Year) _____ (Month) _____ (Day)

Parent/Guardian Name: _____ (First) _____ (Last)

## ADDITIONAL CONTACT INFORMATION

1. ❑ Spouse/Partner ❑ Mother ❑ Father ❑ Legal Guardian ❑ Other _____ ❑ Address same as applicant

Name: _____ Telephone: (_____) _____
Home

Address: _____ _____ _____ _____
Suite# / Street # / Street Name City Prov Postal Code

Email: _____

2. ❑ Spouse/Partner ❑ Mother ❑ Father ❑ Legal Guardian ❑ Other _____ ❑ Address same as applicant

Name: _____ Telephone: (_____) _____
Home

Address: _____ _____ _____ _____
Suite# / Street # / Street Name City Prov Postal Code

Email: _____

## MEDICAL INFORMATION: TO BE COMPLETED BY PHYSICIAN

Applicant may also submit a document stating diagnosis, signed and dated by a physician.

Applicant Name: _____

Diagnosis (Please Specify): _____
Please contact Muscular Dystrophy Canada for a list of neuromuscular disorders covered by our organization or visit us online at **www.muscle.ca**

Date of diagnosis: _____ Location: _____ _____
Year / Month / Day Hospital / Clinic Name City / Town

Neuromuscular Specialist: _____ Telephone: (_____) _____
Please print name Neuromuscular Specialist

Neuromuscular Clinic Applicant is attending: _____

Mailing Address: _____ _____ _____ _____
Suite# / Street # / Street Name City Prov Postal Code

Family Physician: _____ Telephone: (_____) _____
Please print name [medical office stamp acceptable]

Mailing Address: _____ _____ _____ _____
Suite# / Street # / Street Name City Prov Postal Code

SIGNATURE: _____ Date: _____ _____ _____
Specialist or family physician Year Month Day

## MUSCULAR DYSTROPHY CANADA OFFICE USE ONLY:

Registration received by: _____ Date: _____ Information Package sent: _____
Year / Month / Day

**Return the completed form to the appropriate Regional office, attention: Services**

*Updated: August 23, 2011*


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