REGISTRATION FORM

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 umbrella, signed by a physician or a health professional. You must be a Canadian citizen, landed immigrant, or refugee resident in Canada. Please visit our web site www.muscle.ca where you can find the comprehensive list of neuromuscular disorders covered under by our organization.

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 services staff.

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: ....
(mandatory if available)

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
(please specify)

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/HEALTH PROFESSIONAL

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

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

Doctor: .... Telephone: (..........) ....
Please print name [medical office stamp acceptable]

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

SIGNATURE: .... Date: ....
Health professional or doctor Year Month Day

MUSCULAR DYSTROPHY CANADA OFFICE USE ONLY:

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

Return the completed form to :

Updated: Nov 17, 2017

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