ALS Society of Canada | Société canadienne de la SLA www.als.ca

CLIENT REGISTRATION FORM

CLIENT INFORMATION	
Surname :	☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Other : __________
First name :	Date of Birth (MM/DD/YYYY) :
Middle name(s) :	Gender : ☐ Male ☐ Female ☐ Not Identified
Relationship Status : ☐ Single ☐ In a Relationship	☐ Married ☐ Separated / Divorced ☐ Widowed
Address :	Email :
City :	Home # : ( )
Province :	Cell # : ( )
Postal Code :	Work # : ( )
Is the above address : ☐ Home ☐ Hospital ☐ Long-term Care ☐ Other	Do you live alone? ☐ Yes ☐ No
Preferred Language: ☐ English ☐ French ☐ Other : _______________	**Preferred method of communication :** ☐ Email ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text
Preferred Contact (if different than client)	
Surname :	☐ Spouse ☐ Parent ☐ Son ☐ Daughter
First name :	☐ Other : ________________
Address :	Email :
City :	Home # : ( )
Province :	Cell # : ( )
Postal Code :	Work # : ( )
Secondary Contact Person (Optional)	
Surname :	☐ Spouse ☐ Parent ☐ Son ☐ Daughter
First name :	☐ Other : ________________
Address :	Email :
City :	Home # : ( )
Province :	Cell # : ( )
Postal Code :	Work # : ( )
Consent to speak with contacts listed above:	☐ Yes ☐ No
If you have children 21 or under, what year(s) were they born? _______________________, _______________________ , _______________________ , _______________________	
Have you served in the Military or are you a Veteran?	☐ Yes ☐ No
Additional Information :	

393 University Avenue, Suite 1701, Toronto, ON M5G 1E6 **T 416-497-2267** | **F 416-497-8545** | **TF 1-800-267-4257**

Amyotrophic Lateral Sclerosis Society of Canada Charitable Registration Number: 10670-8977-RR0002
Numéro d'enregistrement d'organisme de bienfaisance de la Société canadienne de la sclérose latérale amyotrophique : 10670-8977-RR0002

MEDICAL INFORMATION	
Family Physician :	
Address :	
Telephone : ( )	Fax : ( )
Neurologist :	
Address :	
Telephone : ( )	Fax : ( )
What is your diagnosis? ☐ ALS ☐ PLS ☐ Kennedy's Disease	
Date of your diagnosis (MM/DD/YYYY) :	
Have you been to any ALS Clinic? ☐ Yes ☐ No If yes, which one? ____________________	
INSURANCE COVERAGE	
Do you or your spouse have Extended Health Benefits? ☐ Yes ☐ No	
Name of Health Benefits Provider :	
EMPLOYMENT HISTORY INFORMATION	
Client Status of Employment : ☐ Current – Full-time ☐ Current – Part-time ☐ Retired ☐ Medical leave ☐ Unemployed ☐ Other ____________	
Client Occupation :	

PRIVACY STATEMENT

The ALS Society of Canada respects your privacy. We protect your personal information and adhere to all legislative requirements with respect to protecting your privacy. We do not rent, sell or trade our mailing lists. The information you provide will be used to deliver services and to keep you informed and up to date on the activities of the ALS Society of Canada, including newsletters, programs, services, special events, donations and opportunities to volunteer. Please notify us of any changes by phone at 1-800-267-4257 or via email at info@als.ca, and we will gladly accommodate your request.

I certify that the information contained in this form is true, correct and complete to the best of my knowledge and that I have read and understood the implications of the privacy statement given above. I authorize the ALS Society of Canada to carry out necessary inquiries and obtain or release personal information for the purpose of confirming or clarifying the information provided and for service delivery purposes.

Signature of client (or legally authorized representative) : ____________________

Form completed by : ____________________

(print name)

Signature : ____________________ *Telephone :* ____________________