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: ____

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? __________________________________

____

How do you want to receive updates and information about meetings?

- ☐ **By Mail**
- ☐ **By Email** __________________________________**Email Address**

I WOULD LIKE TO RECEIVE INFORMATION ON:

_______ Support Group Meetings (Patients and Caregivers together)
_______ Caregivers' Days in September (for Caregivers only)
_______ One-on-one communication with other ALS Patients & Families
_______ Patient Services Program of the Society
_______ Volunteer Program & volunteer opportunities of the Society
_______ ALS411 booklets for Children and Teens
_______ Fundraising Events
_______ Making a gift (Stock Donation, Life Insurance, Gift of Annuities, etc.)
_______ Making a gift through my will

APPLICATION FOR FRIENDS &/OR FAMILY MEMBERSHIP(S)

Choose one of the three options for membership package:
NOTE: NO FEE FOR PATIENT MEMBERSHIP

☐ $250.00 Life Member ☐ $40.00 Family Membership ☐ $25.00 Individual Membership

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Mr. & Mrs.

Mailing Address:

If Family Membership, please write the name of other family members and relationship:

Name: (Dr./Mr./Mrs./Ms./Mr. & Mrs.)	**Relationship**
1.	
2.	
3.	

☐ **YES, I WOULD LIKE TO MAKE A DONATION TO THE ALS SOCIETY OF BC**

☐ **One time donation** ☐ **Through the Monthly Giving Program of the Society**

☐ $125.00 ☐ $100.00 ☐ $75.00 ☐ $50.00 ☐ $35.00 ☐ $25.00 ☐ $15.00 __________Other Amount

Name of Donor:____

Choose one of the following 3 options to pay your membership fee and donation:

☐ **1. CHEQUE** Send post-dated cheques. Please make cheques payable to ALS Society of BC.

☐ **2. CREDIT CARD**: ☐ Visa ☐ MasterCard ☐ Amex

Name on the Credit Card:

Credit Card Number	Expiration Date	Security Code # (3 digit for Visa & MasterCard at the back of the card & 4 digit at the front of the Amex card)

☐ 3. **DEBIT MY BANK ACCOUNT** Please attach void cheque.

NOTE FOR MONTHLY GIVING PROGRAM DONORS

Preferred charge date: ____1st of the Month _______15th of the Month ____________ Other Preference

Note: The bank/credit card account will be charged on the next business day if the schedule date falls on a weekend or holiday.

- I, as the bank/credit card holder of the account, authorize the ALS Society of BC to debit my donation from my bank account/credit card every month.
- I understand that I can cancel my direct donation at any time, simply through phone call or a written notice to ALS Society of BC
- A tax receipt for my monthly donation will be issued to me every December of each year.

Signature of Account Holder___________________________ Date:_______________

ALS Society of BC
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