



AMYOTROPHIC LATERAL SCLEROSIS SOCIETY OF BRITISH COLUMBIA

The **ALS Society of BC** is a charitable organization dedicated to providing direct support to ALS patients, along with their families and caregivers, to ensure the best quality of life possible while living with ALS. Through assisting research, we are committed to find the cause of, and cure for Amyotrophic Lateral Sclerosis (ALS).

Through fundraising and donations, the society is able to provide services and programs at no cost to ALS patients and their families.

### PATIENT MEMBERSHIP APPLICATION FORM

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: \_\_\_\_\_

ALS Society of BC

1233 – 13351 Commerce Parkway, Richmond BC V6V 2X7 (PH)604-278-2257 (FX)604-278-4257 (E) info@alsbc.ca

[www.alsbc.ca](http://www.alsbc.ca) Charitable Registration # 10670 8985 RR0001



FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

NEUROLOGIST: \_\_\_\_\_ PHONE: \_\_\_\_\_

YES NO **Diagnosis of ALS, ALS FTD or PLS confirmed by the ALS Centre Neurologist.**

\_\_\_\_\_  
**Signed**

\_\_\_\_\_  
**Print Name of Neurologist**

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.

<input type="checkbox"/> <b>2. CREDIT CARD:</b> <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> 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:    \_\_\_\_ 1<sup>st</sup> of the Month    \_\_\_\_ 15<sup>th</sup> 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:** \_\_\_\_\_