The ALS Society of BC is charitable non- government funded 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.

NOTE: Save this file on your desktop in order to fill out this form and email back to alexandra@alsbc.ca

PATIENT REGISTRATION FORM

Please provide us with the following information, which will be treated in strict confidence.
There is no registration fee for ALS Patients are Extended Members of the ALS Society of BC

DIAGNOSIS DATE: ____________________ AGE AT DIAGNOSIS: ____________________

SURNAME: ____________________ **FIRST NAME:** ____________________

☐ MALE ☐ FEMALE DATE OF BIRTH: ____________________

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED COMMON-LAW

SPOUSE'S NAME: ____

STREET ADDRESS: ____

CITY: ____________ PROVINCE: ____________ POSTAL CODE: ____________

PHONE (C): ____________________ (H): ____________________

EMAIL: ____

ARE YOU THE ONLY PERSON LIVING AT THIS ADDRESS? ☐ YES ☐ NO

PRIMARY CAREGIVER: ____

RELATIONSHIP: ____

STREET ADDRESS: ____

CITY: ____________ PROVINCE: ____________ POSTAL CODE: ____________

PHONE (C): ____________________ (H): ____________________

EMAIL: ____

NEXT OF KIN OR OTHER FAMILY MEMBERS: ____________________ Relationship:____________

STREET ADDRESS: ____

CITY: ____________ PROVINCE: ____________ POSTAL CODE: ____________

PHONE (C): ____________________ (H): ____________________

EMAIL: ____

AMYOTROPHIC LATERAL SCLEROSIS SOCIETY OF BRITISH COLUMBIA

NEUROLOGIST: ________________________ PHONE: ________________________

DIAGNOSIS OF: ☐ ALS ☐ PLS ☐ KENNEDY DISEASE

*IF NEUROLOGIST IS NOT LOCATED AT THE ALS CENTRE AT GF STRONG, PLEASE INCLUDE LETTER OF DIAGNOSIS FROM YOUR NEUROLOGIST

DOES YOUR FAMILY HAVE EXTENDED BENEFITS, VETERANS AFFAIRS CANADA OR PROVINCIAL SOCIAL PROGRAMS (MINISTRY) ☐ YES ☐ NO

*IF YES PLEASE ADVISE: ____

ARE YOU CURRENTLY EMPLOYED?: FULL TIME PART TIME NO RETIRED

BC CARE CARD #: ____

DO YOU HAVE CHILDREN AGED: ☐ 0 - 12 ☐ 13-18 19-21 22+ NO

I WOULD LIKE TO RECEIVE INFORMATION ON:

- ☐ Summer Camp (Ages 8 - 17)
- ☐ Support Group Meetings (Patients and Caregivers together)
- ☐ Patient Services Program of the Society
- ☐ Volunteer Program & Volunteer opportunities of the Society
- ☐ ALS 411 Booklets for Children
- ☐ ALS 411 Booklets for Teens
- ☐ ALS Guide (www.alsbc.ca/programs-services/)
- ☐ Fundraising Events
- ☐ Making a gift (through Will, Stock Donation, etc)

Do you want us to contact your family physician to provide information about ALS?

Family Physician Name: ________________________ Phone #: __________________

IF THERE ARE ANY QUESTIONS REGARDING FILLING OUT THE MEMBERSHIP FORM PLEASE CONTACT THE PATIENT SERVICES COORDINATOR AT 1-800-708-3228 / EXT. 226 or 231 OR EMAIL alexandra@alsbc.ca

ALS SOCIETY OF BC

1228-13351 Commerce Parkway, Richmond BC V6V 2X7

www.alsbc.ca Charitable Registration # 10670 8985 RR0001

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:

Phone #: **Email:**

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:________________