



ALS CLIENT REGISTRATION FORM

APPLICANT INFORMATION	
Surname:	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Other: _____
First name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Middle name(s):	Date of Birth (M/D/Y):
Address:	
City:	Province:
Postal Code:	Telephone #: ()
Email:	Cell #: ()
Alternate Contact Person:	
<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Other: _____	
Surname:	First name:
Address:	
City:	Province:
Postal Code:	Daytime Telephone #: ()
Email:	Evening Telephone #: ()
Secondary Emergency Person:	
<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Other: _____	
Surname:	First name:
Address:	
City:	Province:
Postal Code:	Daytime Telephone #: ()
Email:	Evening Telephone #: ()
Additional Information/Dependants:	
Have you received a copy of "A Manual for People Living with ALS"? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If not, would you like to receive a copy now? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICAL INFORMATION	
Family Physician:	
Address:	
Telephone #: ()	Fax #: ()
Neurologist:	Date of your diagnosis (M/D/Y):
Address:	
Telephone #: ()	Fax #: ()
Other Medical Conditions/Concerns:	
Have you been to any ALS Clinic? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, which one? _____	
Would you like the Society to send your physician a CD regarding ALS? <input type="checkbox"/> Yes <input type="checkbox"/> No	

INSURANCE COVERAGE (NB: We will work with your insurance provider to ensure your benefits are being utilized for your healthcare..)
Do you or your spouse have Extended Health Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Health Benefits Provider:

EMPLOYMENT HISTORY INFORMATION
Client Status of employment: <input type="checkbox"/> Current <input type="checkbox"/> Retired <input type="checkbox"/> Medical leave <input type="checkbox"/> Other: _____
Client Place of Employment:
Client's Spouse - Status of employment: <input type="checkbox"/> Current <input type="checkbox"/> Retired <input type="checkbox"/> Medical leave <input type="checkbox"/> Other: _____
Client's Spouse – Place of Employment:

PRIVACY STATEMENT
"The ALS Society of Ontario 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 Ontario, including newsletters, programs, services, special events, donations and opportunities to volunteer. If at any time you wish to be removed from any of these contacts simply contact us by phone at 1-866-611-8545 or via email at info@alsont.ca , and we will gladly accommodate your request."
<i>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 Ontario 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.</i>
Signature of applicant (or legally authorized representative): _____

FOR OFFICE USE ONLY	Registration Number:
Date Application Rec'd:	Date Manual sent:
Processed by:	Physician CD sent: