Registration Form

MUSCULAR DYSTROPHY CANADA
DYSTROPHIE MUSCULAIRE CANADA

Muscular Dystrophy Canada's mission is to enhance the lives of those affected with neuromuscular disorders by continually working to provide ongoing support and resources while relentlessly searching for a cure through well-funded research. Muscular Dystrophy Canada provides registered clients with a range of services, including support, information, education, advocacy and equipment.

To register, you must have a confirmed diagnosis of a neuromuscular disorder under the Muscular Dystrophy umbrella, signed by a physician or a health professional. You must be a Canadian citizen, landed immigrant, or refugee resident in Canada. Please visit our web site www.muscle.ca where you can find the comprehensive list of neuromuscular disorders covered under by our organization.

Muscular Dystrophy Canada (MDC) collects personal information for a variety of purposes including the delivery of services, fundraising, quality management, research, billing and meeting legal and regulatory requirements.

MDC utilizes several safeguard measures to protect personal information and keep it confidential and will not share any personal information with any third parties unless it is directly related to the delivery or enhancement of the services that MDC provides or unless a Canadian law requires it. Personal information that is no longer required to fulfill the identified purposes will be destroyed, erased, or made anonymous. MDC has guidelines and procedures to prevent unauthorized access and to govern the destruction of personal information. The full MDC Personal Information Protection (Privacy) Policy is available on the MDC website or by request.

For more information about our privacy policy or Muscular Dystrophy Canada, please call 1-800-567-2873 or visit www.muscle.ca.

APPLICANT INFORMATION: (TO BE COMPLETED BY APPLICANT/PARENT/GUARDIAN)

PLEASE PRINT

Preferred Language: ☐ English ☐ French

Salutation: ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Other: _____ Gender: ☐ Male ☐ Female

Applicant Name: _____ (First) _____ (Initials) _____ (Last) Date of Birth: _____ (Year) _____ (Month) _____ (Day)

Home Address: _____ (Suite# / Street # / Street Name) _____ (City) _____ (Prov) _____ (Postal Code)

Mailing Address: _____ (Suite# / Street # / Street Name) _____ (City) _____ (Prov) _____ (Postal Code)

Telephone: _____ (Residence) _____ (Business) _____ (Cell)

Email: _____

(mandatory if available)

Status: ☐ Canadian Citizen ☐ Landed Immigrant ☐ Refugee Resident ☐ Other _____

How did you hear about Muscular Dystrophy Canada? ☐ Neuromuscular Clinic ☐ Internet ☐ Caregiver ☐ Healthcare Practitioner ☐ Word of Mouth ☐ Family Member ☐ Other: _____

I fully understand the reasons Muscular Dystrophy Canada (MDC) has requested my personal information and I give consent to MDC to use my personal information for the purposes outlined. I also understand that I may withdraw my consent at any time, subject to legal or contractual obligations and reasonable notice, and that MDC will inform me of the implications of such withdrawal.

SIGNATURE: _____ (Applicant or Parent / Guardian (if application is under 18 years old)) Date: _____ (Year) _____ (Month) _____ (Day)

Parent/Guardian Name: _____ (First) _____ (Last)

ADDITIONAL CONTACT INFORMATION

1. ❑ Spouse/Partner ❑ Mother ❑ Father ❑ Legal Guardian ❑ Other _____ (please specify) ❑ Address same as applicant

Name: _____ Telephone: _____ Home

Address: _____ _____ _____ _____
Suite# / Street # / Street Name | City | Prov | Postal Code

Email: _____

2. ❑ Spouse/Partner ❑ Mother ❑ Father ❑ Legal Guardian ❑ Other _____ ❑ Address same as applicant

Name: _____ Telephone: _____ Home

Address: _____ _____ _____ _____
Suite# / Street # / Street Name | City | Prov | Postal Code

Email: _____

MEDICAL INFORMATION: TO BE COMPLETED BY PHYSICIAN/HEALTH PROFESSIONAL

Applicant may also submit a document stating diagnosis, signed and dated.

Applicant Name: _____

Diagnosis (Please Specify): _____
Please contact Muscular Dystrophy Canada for a list of neuromuscular disorders covered by our organization or visit us online at **www.muscle.ca**

Date of diagnosis: _____ Location: _____ _____
Year / Month / Day | Hospital / Clinic Name | City / Town

Neuromuscular Specialist: _____ Telephone: _____
Please print name | Neuromuscular Specialist

Neuromuscular Clinic Applicant is attending: _____

Mailing Address: _____ _____ _____ _____
Suite# / Street # / Street Name | City | Prov | Postal Code

Doctor: _____ Telephone: _____
Please print name [medical office stamp acceptable]

Mailing Address: _____ _____ _____ _____
Suite# / Street # / Street Name | City | Prov | Postal Code

SIGNATURE: _____ Date: _____ _____ _____
Health professional or doctor | Year | Month | Day

MUSCULAR DYSTROPHY CANADA OFFICE USE ONLY:

Registration received by: _____ Date: _____ Information Package sent: _____
Year / Month / Day

Muscular Dystrophy Canada complies with the Association of Fundraising Professional's Donor Bill of Rights and is committed to protecting the privacy of your personal information. The information you provide is used to assist in the administration and acknowledgement of your gift, to issue tax receipts and update you on Muscular Dystrophy Canada. If you do not wish to receive future communications from Muscular Dystrophy Canada, please check here. ❑

Submit completed application to:
150 Isabella St, Suite 301, Ottawa, ON K1S 1V7
Toll-Free: 1-800-567-2873 Fax: 613-567-2288
Email: registration@muscle.ca