

Registration Form



Muscular Dystrophy Canada's (MDC) 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 MDC's umbrella, signed by a physician or a healthcare professional. Please visit our web site www.muscle.ca where you can find the comprehensive list of neuromuscular disorders covered 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. 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 I communicate in: English French
(select all that apply)

Salutation: Mr. Mrs. Ms. Miss Other: _____

Gender: Male Female Non-Binary Other: _____ Prefer not to disclose

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

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

Mailing Address: _____
(If different than above) Suite # / Street # / Street Name City Prov Postal Code

Telephone: _____
Residence Business Cell

Email: _____
(mandatory if available)

Status: Canadian Citizen Landed Immigrant Other _____

How did you hear about Muscular Dystrophy Canada?
 Neuromuscular Clinic Social Media Caregiver
 Healthcare Provider Word of Mouth Family Member
 MDC Website 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. I also give MDC permission to contact the signing healthcare professional to confirm the diagnosis, ask follow up questions for eligibility purposes.

SIGNATURE: _____ Date: _____
Applicant (18+), Parent / Guardian, or Substitute Decision Maker Year Month Day

Parent/Guardian or Substitute Decision Maker Name: _____
First Last

MEDICAL INFORMATION: To be completed by Neuromuscular Regulated Clinician (i.e. neurologist or allied health care provider or medical doctor)*

* I don't have a Neuromuscular Regulated Clinician and I would like to have support in finding one

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

Applicant Name: _____

Diagnosis: _____

(Please provide specific information about diagnosis: e.g. sub-type, genetic testing findings if applicable)

If you are unsure if the applicants disorder is covered please visit muscle.ca or contact research@muscle.ca

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

Signing healthcare professional : _____ Telephone: _____
Please print name [medical office stamp acceptable]

Title / Profession: _____ Email Address: _____

- I give permission for MDC to contact me should they have any questions about the information stated in this section and to answer any questions that might help to determine eligibility.
- I am a regulated healthcare professional and I am signing this to the best of my ability and verifying the information is accurate to the best of my knowledge.

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: _____ Date: _____
Healthcare professional Year Month Day

Neurologist/Neuromuscular Specialist: _____ Telephone: _____
(If different than above) Please print name

Neuromuscular Clinic Applicant is attending: _____

Email Address: _____

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

FAMILY MEMBER INFORMATION

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

Preferred Language: English French I communicate in: English French
(select all that apply)

Salutation: Mr. Mrs. Ms. Miss Other: _____

Gender: Male Female Non-Binary Other: _____ Prefer not to disclose

Name: _____ Date of Birth: _____
Year Month Day

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

Email: _____ Telephone: _____
Residence

Status: Canadian Citizen Landed Immigrant Other _____

Do you agree to be registered as a Family Member with MDC? Yes No

I give permission for MDC to contact me should they have any questions about the information stated in this section and to answer any questions that might help to determine eligibility.

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: _____ Date: _____
Year Month Day

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

Preferred Language: English French I communicate in: English French
(select all that apply)

Salutation: Mr. Mrs. Ms. Miss Other: _____

Gender: Male Female Non-Binary Other: _____ Prefer not to disclose

Name: _____ Date of Birth: _____
Year Month Day

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

Email: _____ Telephone: _____
Residence

Status: Canadian Citizen Landed Immigrant Other _____

Do you agree to be registered as a Family Member with MDC? Yes No

I give permission for MDC to contact me should they have any questions about the information stated in this section and to answer any questions that might help to determine eligibility.

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: _____ Date: _____
Year Month Day

Submit completed application to:

40 Eglinton Avenue East, Suite 500 Toronto, Ontario M4P 3A2
Toll-Free: 1 800 567-2873 Fax: 1 866 726-8732
Email: registration@muscle.ca