Registration Form

MUSCULAR DYSTROPHY CANADA
DYSTROPHIE MUSCULAIRE CANADA

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 MDCs 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: _____ (First) _____ (Initials) _____ (Last) Date of Birth: _____ (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: _____ (Applicant (18+), Parent / Guardian, or Subsitute Decision Maker) Date: _____ (Year) _____ (Month) _____ (Day)

Parent/Guardian or Subsitute 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 am signing this to the best of my ability and verifying the information is accurate to the best of my knowledge.

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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

Submit completed application to:
4211 Yonge St, Suite 316, Toronto, ON M2P 2A9
Toll-Free: 1 800 567-2873 Fax: 1 866 726-8732
Email: registration@muscle.ca

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 _____

Acceptez-vous d'être inscrit(e) auprès de DMC en tant que membre de famille ? ❑ Oui ❑ Non

❑ 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.

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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