

At Muscular Dystrophy Canada, our mission is to enhance the lives of individuals and families affected by neuromuscular disorders. We are here to support you and your family every step of the way by providing resources, building community, and relentlessly pursuing a cure through well-funded research. Muscular Dystrophy Canada provides registrants with a range of services, including support, information, education, advocacy, and equipment.

Muscular Dystrophy Canada has a comprehensive list of neuromuscular disorders that fall under our umbrella. We ask that a physician or healthcare professional confirm your condition; however, if you don't see your disorder listed, or if you are still navigating a diagnosis, please contact our Research Hotline (1-800-567-2873 ext. 9037 or email [research@muscle.ca](mailto:research@muscle.ca)), as we may be able to help. If you do not have access to a physician or healthcare professional, our Research Hotline can also provide support.

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

Muscular Dystrophy Canada 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 Muscular Dystrophy Canada provides or unless a Canadian law requires it. Muscular Dystrophy Canada has guidelines and procedures to prevent unauthorized access and to govern the destruction of personal information. The full Muscular Dystrophy Canada Personal Information Protection (Privacy) Policy is available on the Muscular Dystrophy Canada website or by request.

For more information about our privacy policy or Muscular Dystrophy Canada, please call 1-800-567-2873 or visit [muscle.ca](http://muscle.ca).

## APPLICANT INFORMATION (To be completed by Applicant, Parent/Guardian, or Caregiver)

[ PLEASE PRINT ]

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

Salutation:  Mr  Mrs  Ms  Miss  Other: .....  
(please specify)

Gender:  Male  Female  Non-Binary  Other: .....  Prefer not to disclose  
(please specify)

Applicant Name: .....  
First name / Initial(s) / Last name

Date of Birth: .....  
YYYY / MM / DD

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: .....  
Cell Residence Business

Email: .....  
(mandatory if available)

## APPLICANT INFORMATION (Continued)

Status:  Canadian Citizen  Landed Immigrant  Other: \_\_\_\_\_  
(please specify)

### How did you hear about Muscular Dystrophy Canada?

Neuromuscular Clinic  Social Media  Caregiver  Healthcare Provider  Word of Mouth  
 Family Member  Muscular Dystrophy Canada Website  Other: \_\_\_\_\_  
(please specify)

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 YYYYY/MM/DD

Parent/Guardian or Substitute Decision Maker Name: \_\_\_\_\_  
First name / Last name

## FAMILY MEMBER(S) INFORMATION

1.  Spouse/Partner  Mother  Father  Legal Guardian  Other: \_\_\_\_\_  
(please specify)

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

Salutation:  Mr  Mrs  Ms  Miss  Other: \_\_\_\_\_  
(please specify)

Gender:  Male  Female  Non-Binary  Other: \_\_\_\_\_  Prefer not to disclose  
(please specify)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
YYYY/MM/DD

Home Address (If different from Applicant's): \_\_\_\_\_  
Suite # / Street # / Street Name

City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Status:  Canadian Citizen  Landed Immigrant  Other: \_\_\_\_\_  
(please specify)

Do you agree to be registered as a Family Member with Muscular Dystrophy Canada?  Yes  No

I give permission for Muscular Dystrophy Canada 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 has requested my personal information and I give consent to Muscular Dystrophy Canada 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 Muscular Dystrophy Canada will inform me of the implications of such withdrawal.

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_  
YYYY/MM/DD

## FAMILY MEMBER(S) INFORMATION (Continued)

2.  Spouse/Partner  Mother  Father  Legal Guardian  Other: \_\_\_\_\_  
(please specify)

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

Salutation:  Mr  Mrs  Ms  Miss  Other: \_\_\_\_\_  
(please specify)

Gender:  Male  Female  Non-Binary  Other: \_\_\_\_\_  Prefer not to disclose  
(please specify)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
YYYY/MM/DD

Home Address (If different from Applicant's): \_\_\_\_\_  
Suite # / Street # / Street Name

City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Status:  Canadian Citizen  Landed Immigrant  Other \_\_\_\_\_  
(please specify)

Do you agree to be registered as a Family Member with Muscular Dystrophy Canada?  Yes  No

I give permission for Muscular Dystrophy Canada 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 has requested my personal information and I give consent to Muscular Dystrophy Canada 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 Muscular Dystrophy Canada will inform me of the implications of such withdrawal.

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_  
YYYY/MM/DD

## MEDICAL INFORMATION (To be completed by Neuromuscular Regulated Clinician i.e. neurologist or allied healthcare 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 applicant's disorder is covered please visit [muscle.ca](http://muscle.ca) or contact [research@muscle.ca](mailto:research@muscle.ca)

Date of diagnosis: \_\_\_\_\_ Location: \_\_\_\_\_  
YYYY/MM/DD Hospital / Clinic Name City / Town

## MEDICAL INFORMATION (Continued)

**Signing healthcare professional:** .....  
*Please print name (medical office stamp acceptable)*

**Telephone:** .....

**Title / Profession:** .....

**Email:** .....

- I give permission for Muscular Dystrophy Canada 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 has requested my personal information and I give consent to Muscular Dystrophy Canada 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 Muscular Dystrophy Canada will inform me of the implications of such withdrawal.

**SIGNATURE:** ..... **Date:** .....  
*Healthcare professional* *YYYY/MM/DD*

**Neurologist/Neuromuscular Specialist:** .....  
*(If different than above)* *Please print name*

**Telephone:** .....

**Neuromuscular Clinic Applicant is attending:** .....

**Email Address:** .....

**Mailing Address:** .....  
*Suite # / Street # / Street Name*

.....  
*City* *Prov* *Postal Code*

## SUBMIT COMPLETED APPLICATION BY:

**Mail:** 4211 Yonge St, Suite 316, Toronto, ON M2P 2A9

**Fax:** 1-866-726-8732

**Email:** [registration@muscle.ca](mailto:registration@muscle.ca)