Registration for ALS Canada

Registration Date:	
What is your diagnosis?	□ ALS □ PBP □ PLS □ HSP □ Kennedy's Disease □ PMA
Client Name:	
Title:	□ Mr. □ Mrs. □ Ms. □ Dr. □ Other: _____
Preferred Name:	
Date of Birth:	
Gender:	□ Male □ Female □ Non-Binary □ I prefer not to say □ Other: _____
Which of the following best describes you?	□ Black □ Asian □ First Nations, Inuit, or Metis □ Latino □ Middle Eastern □ White □ A race not listed □ I prefer not to say □ Other: _____
Relationship Status:	□ Single □ Common Law □ Married □ Separated □ Divorced □ Widowed (The definition of a common-law partner should be read as "an individual who is (ordinarily) cohabiting." After the one-year period of cohabitation has been established, the partners may live apart for periods of time while still maintaining a common-law relationship)
Email:	
Cell #:	
Home #:	
How would you like us to communicate with you?	□ Email □ Home Phone □ Work Phone □ Cell Phone □ Text □ Other: _____ **(Please note that some communications will be sent by email)**
Primary language spoken at home	■ English □ French □ Other: _____
Do you live alone?	■ Yes □ No
Client Address:	
Is the above address:	□ House or Apartment □ Hospital □ Long-term Care □ Other: _____
Please indicate who your preferred contact is:	□ Self □ Alternative Contact

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(1) Alternative Contact Name:	
(1) Alternative Contact Relationship:	□ Spouse □ Parent □ Son □ Daughter □ Other: _____
(1) Alternative Contact Email:	
(1) Alternative Contact Home or Cell #	
(1) Alternative Contact Address: □ Same as above	
(2) Alternative Contact Name:	
(2) Alternative Contact Email:	
(2) Alternative Contact Phone:	
Have you served in the Military or are you a veteran?	□ Yes □ No
Number of children under the age of 18	
Child 1: Name & DOB	
Child 2: Name & DOB	
Child 3: Name & DOB	
Child 4: Name & DOB	
Date of your diagnosis:	
Who is your neurologist?	
Have you been to any ALS Clinic?	□ Yes □ No
If yes, which one?	□ ALS Clinic – McMaster University Medical Care, Hamilton Health Services □ Kingston – Providence Care Hospital □ Motor Neuron Disease Clinic – London Health Sciences □ The Ottawa Hospital Rehab Centre □ ALS Clinic – Sunnybrook Health Sciences Centre □ Other: _____
Do you or your spouse have Extended Health Benefits?	□ Yes □ No **If yes, name of Health Benefits Provider:** _____
Client Status of Employment:	□ Current – Full-Time □ Current – Part-Time □ Disability □ Retired □ Medical Leave □ Unemployed □ Other: _____
Client Occupation:	

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	Client Income is collected for the sole purpose of analytics. Programs and services are provided to people of all income levels.
Client Income:	
Is there any additional information you would like to provide to ALS at this time?	

By signing below, you agree to the following:

Privacy Statement

The ALS Society of Canada (ALS Canada) respects your privacy. We protect your personal information and adhere to all legislative requirements in the protection of your privacy. 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 Canada, including newsletters, programs, services, advocacy, awareness, and fundraising initiatives. Please see our privacy policy at www.als.ca/privacy-policy for further information. We do not rent or sell our mailing lists.

You may receive virtual visits as part of the services you receive from ALS Canada. While beneficial, it is important to acknowledge the limitations and risks of virtual visits, which include the potential for eavesdropping, hacking and software failures. ALS Canada has safeguards in place to limit these risks however they cannot be fully eliminated.

You may withdraw your consent at any time. However, ALS Canada may be limited in the services it may be able to provide without consent for the collection, disclosure and use of personal information. Please notify us of any changes by phone at 1-800-267-4257 or via email at communityservices@als.ca.

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I certify that the information contained in this form is true, correct, and complete to the best of my knowledge. I have read, understood and consent to the collection, disclosure and use of personal information as noted in the privacy statement above and the ALS Canada privacy policy. I also consent to the collection, disclosure and use of personal information through virtual visits.

I agree to adhere to the ALS Society of Canada “Service Agreement.” I understand that registering for and obtaining services from ALS Canada is voluntary and that ALS Canada has the right to refuse services should I or anyone I am affiliated with demonstrate behavior such as physical, verbal, and/or emotional intimidation or harassment towards ALS Canada employees, volunteers, or third-party equipment vendors.

Name of person completing form	
Person completing this form email:	
Contact phone number of person completing this form:	
Signature of person completing this form:	