Association Lavalloise des Personnes Aidantes

REGISTRATION FORM

Membership number: _____

Member: organizational ☐
Member: individual caregiver ☐
Member: individual non-caregiver ☐

Caregiver details

Last name: _____

First name: _____

Gender: F ☐ M ☐

Address: _____

Postal Code: _____ *Same delivery address (newspaper, invoice) :* ☐

Home telephone: _____ Other telephone: _____

E-mail: _____

I agree to receive e-mails from ALPA: ☐

Date of birth: _____ _____ _____ Spoken Languages : _____
month day year

Occupation : _____

Native country: _____ Civil status: _____

Relation to care-receiver: _____

Care-receiver details:

Last name: _____ Spoken languages : _____

First name: _____

Date of birth: _____ _____ _____
month day year

Deficiencies/illnesses: _____

Name of Patient-Navigator (SW, RN): _____ tel.: _____ ext.: _____

Do you receive services from the following organizations?

CISSS ☐ Local community organization ☐ Private sector ☐

Please specify: _____

How did you hear about ALPA? _____

Invoice : E-mail: ☐ Annual account statement: ☐ Bimonthly invoice : by mail ☐

Signature: _____ ***Date:*** _____