Working for a life free of pain.
Pour une vie sans douleur.

DEBRA Canada
Membership Application Form

WHO CAN APPLY?

- Candidates for membership are persons interested in furthering the Corporation's mission and purpose.
- Candidates for membership are EB patients, their relatives, those from the medical community, DEBRA Directors, and those who are closely associated to patient members who have been approved by the DEBRA Canada board of directors.
- **Applicants MUST reside in Canada to qualify for membership**

BENEFITS OF BECOMING A DEBRA CANADA MEMBER

1. Members shall be entitled to receive notice of, attend and vote at all meetings of the members of the Corporation.
2. Members will receive regular updates on Programs and Services for Member families.
3. Members receive all general DEBRA Canada news updates (via post, e-blasts, e-newsletters and website postings).
4. Members have applied and been accepted into membership in the Corporation by resolution of the board or in such other manner as may be determined by the board of directors.

HOW TO APPLY:

Complete application form below and submit by email, fax or post.

ATTN: DEBRA Canada Administrative Officer EMAIL: debra@debracanada.org

Subject: MEMBERSHIP APPLICATION FORM

By Fax: 905- 469-1850 (ATTN: DEBRA Canada, MEMBERSHIP REQUEST)

Please Note: Mailing in your application form may result in significant delay in response from our committee

ATTN: DEBRA Canada Membership Request
1500 Upper Middle Rd, Unit #3
PO Box 76035
Oakville, ON, L6M 3H5

If you have any further questions, please contact:

Erin Hoyos, Secretary/Administrative Officer: ehoyos@debracanada.org

Membership Application Form

SECTION 1.

I am: ☐ **An Adult EB Patient (19 years or older)** *(complete section 1-5 &7)*

☐ **A Parent or Relative Applying on Behalf an EB patient** *(complete section 1-4, 6-7)*

☐ **A Medical Practitioner/ I Work in the Medical Field** *(complete section 1-4 & 8)*

☐ **Closely Associated To An EB Patient Member Family** *(complete section 1-4 &9)*

SECTION 2.

I wish to become a DEBRA Canada Volunteer:

☐ **YES** ☐ **NO**

SECTION 3.

I wish/ consent to receive the DEBRA Canada Newsletter / E-Newsletters. (Option to unsubscribe upon receipt of email)

☐ **YES** **Email Address** ___________________________________

☐ **NO**

SECTION 4.

Tell Us How You Learned About DEBRA Canada

☐ Website ☐ Medical Staff (i.e. Doctor, nurse, social worker)

☐ Media ☐ I know someone with EB

☐ Friend ☐ I attended an Event

☐ Other: (please specify below)

____

SECTION 5: Applicant's Details

Applicant's name:	
Applicant's address:____ City_______________________ Province__________________ Postal Code_____________	
Date of Birth: (MM/DD/YYYY)	Mobile:
Email address:	Day Phone:

SECTION 6: Details of Applicant's Representative

Application Made By: First Name: ___________________________________ Last Name: ____________________________	
Relationship to Applicant: ☐ Parent ☐ Other: (please specific) ____	
Representatives Address Street:____ City: _________________________Province _____________________Postal Code_________________	
Parent Date of Birth: (MM/DD/YYYY)	Representatives Mobile (optional):
Representatives Email address:	Representatives Day Phone:

SECTION 7: Medical Information

Type of EB:
Sub-type (if known)
☐ Doctor's letter with confirmation of diagnosis attached Under the care of (please specify name of Doctor or Dermatologist):

____ Doctor Phone Number: ____________________(For Verification Only)

SECTION 8: I am a Medical Practionner / I Work In the Medical Field

Application made by: First Name: ______________________________Last Name: ___________________________	
I am a : ☐ Doctor ☐ Nurse ☐ Social Worker ☐ Other: (Please Specify Job title) ____________________________	
Institution/Office Address: Street:____ City: ______________________Province ___________________Postal Code_______________	
Date of Birth: (MM/DD/YYYY)	Mobile (optional):
Email address:	Day Phone:

SECTION 9: I Am a Close Friend of an EB Patient Member Family

Application Made By: First Name: ______________________________Last Name: ___________________________	
Mailing Address: Street:____ City: ______________________Province ___________________Postal Code_______________	
Date of Birth: (MM/DD/YYYY)	Mobile (optional):
Email address:	Day Phone:
Please specify how you learned about our organization and why you wish to become a member (Feel free to attach additional page if needed)	

CHECK LIST:

Have you completed and included the following:

- [ ] Completed application form (all relevant fields filled in).
- [ ] A doctor's letter with confirmation of EB diagnosis. (If Applicable)

Please return to the by email fax or post to:

Email: debra@debracanada.org
Subject: Membership Request

By Fax: 905- 469-1850 (ATTN: DEBRA Canada, MEMBERSHIP REQUEST)

Postal Address: DEBRA Canada (MEMBERSHIP REQUST)
1500 Upper Middle Rd, Unit #3, PO Box 76035
Oakville, ON
L6M 3H5

***Please note: postal option may result in longer response time from our membership committee**

Thank you for your membership application!

This page is for 'Office use only'

Application for membership must be reviewed by the DEBRA Canada Board of Directors and all approvals are reviewed granted or declined at the monthly BOD meetings.

Received Date: **MEMBERSHIP REQUST FORM**	Name:
Comments:	
Reviewed by: **DEBRA Canada Officer**	Lead Name:
Comments:	

MEMBERSHIP REQUST		
APPROVED:	Signed:	Date:
Comments:		
Request declined:	Signed:	Date:
Rationale:		

Applicant informed of outcome	
Signed:	Date:
Telephone ☐ Email ☐ Letter ☐	