## Spina Bifida and Hydrocephalus Association of Southern Alberta

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We are delighted to extend our warmest welcome to you as a new member of our Spina Bifida and Hydrocephalus Association. As we strive to support individuals and families affected by Spina Bifida (and related hydrocephalus), it is important for us to maintain accurate records and ensure that our resources are effectively allocated to meet the needs of our members. To this end, we kindly request your cooperation in completing the following documentation.

Pls mail or scan a copy of this completed form to the address at the top of this form.

First & Last name of person with Spina Bifida / Hydrocephalus:	
	DOB (dd/mm/yyyy):
·	has been a permanent resident residing in Southern Alberta since, residing at the following address (street address, city,
Date of Spina Bifida & related Hydrocep	ohalus Diagnosis (dd/mm/yyyy):
Parent / Legal Guardian / Adult with SB,	/H applying for membership (print full name):
Signature:	Date (dd/mm/yyyy):
Myelo Clinic Representative (print full n	name):
Signature:	Date: (dd/mm/yyyy):
Neurosurgeon or Physician confirming S	Spina Bifida a/o related Hydrocephalus diagnosis:
(print full name):	
Office Contact #:	
Signature:	Date: (dd/mm/yyyy):
association can offer. This form allows	ion provided may impact the services and support that the us to better tailor our programs and services to meet the specific fida in Alberta a/o related Hydrocephalus in Southern Alberta.
Sincerely, Program Coordinator, SBHAS, Disclaimer *We can only support individuals with diagnosee	A d Spina Bifida a/o related Hydrocephalus. People who have conditions like SB/H are welcome to

apply for a Friends & Others Membership located on our website.