

Spina Bifida and Hydrocephalus



Association of Southern Alberta

PO Box 6837 Stn D. Calgary, AB T2P 2E9 sbhasa.ca sbhasa.info@shaw.ca

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, 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:

First & Last name of person with Spina Bifida / Hydrocephalus:

_____ DOB (dd/mm/yyyy): _____

I confirm that the above-named person has been a permanent resident residing in Southern Alberta since (dd/mm/yyyy) _____, residing at the following address (street address, city, postal code):

Date of Spina Bifida a/or Hydrocephalus Diagnosis (dd/mm/yyyy): _____

Member / Applicant (print full name): _____

Signature: _____ Date (dd/mm/yyyy): _____

Physician's or Myelo Clinic Representative (print full name): _____

Signature: _____ Date: (dd/mm/yyyy): _____

* I acknowledge that any false information provided may impact the services and support that the association can offer me.

Thank you for your cooperation in completing this form. Your participation allows us to better tailor our programs and services to meet the specific needs of individuals living with Spina Bifida in Alberta.

Should you have any questions or require further assistance, please do not hesitate to contact us.

Sincerely,

Tricia Spruit - Program Coordinator, SBHASA

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