



REGISTRATION FORM

Adult Amputee Program

APPLICANT'S INFORMATION

Last Name _____ First Name _____ Middle Name(s) _____
 Other last name(s) previously used (optional) _____ **Language of preference:** English French
 () - **Date of Birth:** _____ **Gender:** Male Female
 Telephone Number _____ Day /Month/Year _____
 Unit/Suite/Apt _____ Street Number _____ Street Name _____ P.O. Box _____ Rural Route _____
 City/Town _____ Province _____ Postal Code _____ E-mail address _____

AMPUTATION INFORMATION

Date of Amputation _____ **Cause of Amputation:** _____
 Day /Month/Year (e.g., diabetes, motor vehicle accident, etc.)
Level of Amputation: _____ Left Right Bilateral
 (e.g., above or below knee/hip/above or below elbow/hand, etc.)
Additional Amputation Details: _____
 (for partial foot/hand, etc.)
IF MORE THAN ONE AMPUTATION:
Date of Amputation _____ **Cause of Amputation:** _____
 Day /Month/Year (e.g., diabetes, motor vehicle accident, etc.)
Level of Amputation: _____ Left Right Bilateral
 (e.g., above or below knee/hip/above or below elbow/hand, etc.)
Additional Amputation Details: _____
 (for partial foot/hand, etc.)

OTHER FINANCIAL ASSISTANCE

The War Amps does not employ a means test, however, as a charity we need to be advised of any financial assistance that is available to you other than the standard provincial coverage. Are you covered through private insurance (i.e. Manulife, Sun Life, Blue Cross etc.) or any government programs such as social assistance? Please provide details:

Applicant's Signature _____

Date: (Day /Month/Year) _____

PROSTHETIC CENTRE INFORMATION

Name, Address and Telephone Number
