

## *Who is Eligible?*

To be eligible for Friends For Life Membership you must be:

- A current resident of B.C.
- Nineteen (19) years of age or older
- Living with HIV/AIDS, cancer, or other qualifying life-threatening illnesses
- Diagnosed and referred by a licensed B.C. physician

Membership provides you with access to all programs and services. There is no fee for this application, or for any programs and services that we offer.

## *How do I become a Member?*

1. Fill out and sign the application.
2. Have your primary physician complete and sign the Medical Information section (part two). The Medical Information Form must have the Physician's stamp.
3. Return your completed application form to Friends For Life in person, by mail or by fax. We will contact you by phone to review your application.
4. After your application has been reviewed you may be invited to attend a new member orientation.

The Vancouver Friends For Life Society serves as a catalyst to enhance the wellness of individuals living with a life-threatening illness by providing complementary and alternative health and support services.

We are a privately funded not-for-profit organization registered under the British Columbia Society Act.

We offer programs such as support groups, counselling, massage, bodywork, acupuncture, yoga, nutrition and social support programs, mediation and wellness workshops.

All programs and services are offered without charge and are provided by qualified professionals, who volunteer their time and expertise.

[www.friendsforlife.ca](http://www.friendsforlife.ca)



THE VANCOUVER  
**FRIENDS  
FOR LIFE**  
S O C I E T Y

## **Membership Application**

**Diamond Centre For Living**  
1459 Barclay Street  
Vancouver, BC V6G 1J6

**Tel: 604-682-5992**

**Fax: 604-682-3592**

[www.friendsforlife.ca](http://www.friendsforlife.ca)

# Part One Applicant Information

*Information provided is confidential.*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Emergency contact:

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

What life-threatening illness are you living with?

- Cancer   
HIV/AIDS   
Other  \_\_\_\_\_

Only some conditions qualify for membership. Please call for more information before going to your doctor.

How did you hear about Friends For Life?

- Doctor \_\_\_\_\_  
 Health Practitioner \_\_\_\_\_  
 Community Agency \_\_\_\_\_  
 Current Friends For Life Member  
 Other \_\_\_\_\_

May we contact you by phone and leave a voice-mail message regarding this application?

- Yes  No

*I understand and meet the requirements for eligibility to receive programs and services as a Member. I agree to allow Friends For Life to gather my personal information for the purposes of processing my membership application and providing services to me. By signing this document, I am stating that to the best of my knowledge, the preceding information is accurate and complete.*

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Date*

## Part Two Medical Information Form

*To be completed by your primary physician.*

To access the programs and services of Friends For Life, we require confirmation of the following information:

Does your patient have a life-threatening illness?

- Yes  No

What life-threatening is your patient living with?

\_\_\_\_\_  
Please provide your patient's cancer diagnosis and staging where applicable.

\_\_\_\_\_  
Please provide the prognosis for your patient.

In your opinion, how would you anticipate your patient benefitting from programs made available at Friends For Life (FFL)?

\_\_\_\_\_  
Amongst the programs available at FFL, which would you recommend for your patient (i.e. yoga, nutrition, naturopathy, acupuncture, etc.)?

\_\_\_\_\_  
Is there any additional information that may be pertinent in assisting your patient (i.e. mental illness, physical limitations, drug or alcohol use)?

\_\_\_\_\_  
I, (print physician's full name)

\_\_\_\_\_  
being a duly licensed physician in the Province of British Columbia, hereby certify that the aforementioned individual is living with a life-threatening illness. I acknowledge that The Vancouver Friends For Life Society relies upon this certification for qualification of the above named individual.

**Please place your Physicians stamp below:**

*This form is not valid without your stamp*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

*If you have any questions regarding this form, please contact the Wellness Services Manager at 604-682-5992 ext 3.*