Activity Centre for Empowerment (A.C.E.)
Prince George

BRANCH MEMBERSHIP APPLICATION

Membership Type: *Mental Health Service User* Date:_____

*First Name:_____ *Last Name:_____

*Address:_____ Apt #:_____

*City:_____ Postal Code:_____

Telephone:_____ Cell:_____

Email:_____

*Birthdate: YY____ MM____ DD____

Would you like to be part of the ACE Birthday club? Yes ☐ No ☐

Would you be interested in volunteering at ACE? Yes ☐ No ☐

***Emergency Contacts: (One is mandatory)**

1. Name:_____ Phone :_____

Relationship to you:_____

2. Name:_____ Phone :_____

Relationship to you:_____

**Information is mandatory to obtain a membership*

Do you have any allergies or medical conditions that ACE staff should be aware of? (Example: Diabetes, epilepsy, allergy to penicillin) Yes ☐ No ☐

If yes please describe condition and current treatment:_____

_____

_____

Referral Information

* Case Manager:_____ Phone:_____

(Can be social worker/Counsellor or other service provider from Northern Health Mental Health and Addictions Services)

Family Doctor:_____ Phone:_____

*Psychiatrist:_____ Phone:_____

*Diagnosis:_____

*Self Referral: Yes ☐ No ☐ If no, name of person who referred you: _____
(If yes a further referral may be required.)

Do you have a life skills worker? Yes ☐ No ☐

If yes what organization are they from (Example Northern Health, CMHA, BIG, AimHi)

_____

_____

Notes_____

_____

_____

_____

_____

_____

_____

Information is mandatory to obtain a membership

Activity Center for Empowerment (A.C.E.)

Membership Agreement

*I, _____ have read and agree to abide by the Community Standards of the Activity Centre of Empowerment (A.C.E.).

I release A.C.E. from any liability for injuries to myself, or any damage to personal property, while attending the Centre and participation in any activities organized by the Activity Centre for Empowerment. I understand that information on this for m may be shared with Northern Health, and that by signing the membership I consent to this sharing of my personal information.

_____	_____
Signature of member	Date
_____	
Print Name	
_____	_____
Name of Staff Accepting Form	Date
_____	_____
Approved By	Date

For Office Use Only

Date:_____

Fee Paid:_____

A Reason to Hope. The Means to Cope.
British Columbia Schizophrenia Society
Prince George - Northern Interior