

Veterans Affairs Canada/Canadian Forces Beneficiaries Enrolment

Who is completing the form? _____

Information About the Amputee

First name _____ Middle name(s) _____ Last name _____

Preferred name: _____ Other last name(s) previously used (optional): _____

Date of birth: _____ Gender: _____ Preferred pronouns: _____
day/month/year

Address: _____

City: _____ Province: _____ Postal code: _____

For confidentiality and privacy purposes, all mail from The War Amps will be mailed to you at this address.

Phone number: _____ Email: _____

Please state your language preference: English FrenchHow did you learn about The War Amps services for amputees?

Military Service

Military service status: Actively serving Pending release Released

File number: _____ Service number: _____

Regiment: _____

Rank: _____

Pension coverage: Pension Act New Veterans Charter/Veterans Well-being Act Other*If other, please specify:* _____Are you experiencing any issues accessing your VAC/SISIP/DND benefits? Yes No*If yes, please share some details:* _____

Type of Amputation(s)

Please select all amputation types that apply and indicate the location (for bilateral amputations, check both left and right). Provide the cause (at birth, medical or accident) and date of each amputation.

	Left	Right	Cause	Date
Transtibial (below the knee)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Transfemoral (above the knee)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Partial foot	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Syme's	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ankle disarticulation (through the ankle)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Knee disarticulation (through the knee)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Transradial (below the elbow)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Partial hand	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Wrist disarticulation (through the wrist)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Transhumeral (above the elbow)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Elbow disarticulation (through the elbow)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hemipelvectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hip disarticulation (through the hip)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rotationplasty	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Forequarter	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Shoulder disarticulation (through the shoulder)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (please specify): _____				

The amputation(s) is/are the result of a limb length discrepancy of the: Femur and/or Tibia/Fibula

The amputation(s) is/are the result of a limb length discrepancy of the: Humerus and/or Radius/Ulna

The limb length discrepancy is: _____ cm or _____ inches

Additional notes: _____

Cause(s) of Amputation

Please select all that apply and provide the date(s) of each amputation or surgery, if applicable.

At birth

Congenital

Congenital surgical

(As a result of congenital limb deficiency where surgical amputation has been or will be required)

Congenital type:

No cause or diagnosis

Amniotic band syndrome

Fibular hemimelia

PFFD

TARS

Other

Please specify: _____

Medical

Date of diagnosis: _____

Cancer

Meningitis

Diabetes

Vascular

Sepsis

Other

Please specify: _____

Accident

Date of accident: _____

Improvised explosive device

Automobile accident

Farm accident

Lawn mower

Train accident

Electrocution

Frostbite

Grinder accident

Workplace accident

Miscellaneous accident

Please specify: _____

Date(s) of amputation(s)/surgery or surgeries (if applicable): _____

Are you considering pursuing legal action as a result of the cause of amputation (if applicable)? Yes No

Please indicate the prosthetic/rehabilitation centre you attend: _____

Is a prosthetic limb/device currently being made? Yes No

Other Sources of Funding

Are you eligible for funding from any other source, such as social assistance, or do you have personal extended health coverage or group insurance through your place of employment? This will ensure the coverage of artificial limbs is within our funding guidelines.

Yes *Please specify:* _____ No

Release

In consideration of The War Amputations of Canada assisting me through the Program, I, _____, hereby release and forever discharge The War Amputations of Canada of any fault from all claims, demands, damages, actions or causes of action arising, or to arise, whatsoever in law or in equity which I, my heirs, executors, administrators or assigns can, shall or may have because of my involvement in the Association's activities and functions.

Further, I agree to indemnify and save harmless The War Amputations of Canada and their successors and assigns against and from all actions, damages, debts, accounts, claims and demands that may hereafter be brought against them by me or on my behalf because of my involvement with the Association's programs.

Member (print name)

Witness (print name)

Email

Member's signature

Witness' signature

Date: _____
day/month/year

Date: _____
day/month/year

Application Signature

Applicant's signature _____ Date: _____
day/month/year

Consent to Release Information to a Third Party

I acknowledge that The War Amps may need to communicate personal information to a third party in order to provide requested services. Before or at the time The War Amps collects or accesses personal information, the Association will explain the information's intended use. Unless required by law, The War Amps will not use or disclose any personal information that has been collected without documenting the new purpose and obtaining further consent. A photocopy or electronic version of this authorization is as valid as the original. This permission is valid until I withdraw my consent in writing.

I/We authorize The War Amps to release my/our personal information relating to requested services such as accommodation, travel, shipping and special requirements to third parties.

Applicant (print name)

Applicant's signature

Date: _____
 day/month/year

The information collected by The War Amps is for the purpose of funding your needs and providing you with the services you have requested. The War Amps is committed to protecting the privacy of your personal information. Information collected may be processed by a third-party service provider.
Charitable Registration No.: 13196 9628 RR0001