



CANADA'S ISLAND GARDEN INC.
 7 INNOVATION WAY
 CHARLOTTETOWN, PRINCE EDWARD ISLAND, CANADA C1E 0B7

PHONE: (902) 370-5500 FAX: (902) 370-5501
 EMAIL: info@canadasislandgarden.com

REGISTRATION APPLICATION

To be completed by Canada's Island Garden Inc. only
APPLICATION NUMBER

Please complete all sections of the registration application below and submit the completed, signed and dated original application to Canada's Island Garden Inc. Include with this application the original completed Medical Document, signed and dated by your health care practitioner. All information on the application must match that on the Medical Document form. Incomplete forms will result in delay or denial of registration.

SECTION 1: APPLICANT INFORMATION

To be completed by the applicant or by an individual who is responsible for the applicant, referred to in Section 2.

First Name(s)	Middle Name (if applicable)	Last Name
Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone
Email	Fax	
Preferred Contact Method/ Preferred Contact Time		

PRIMARY RESIDENCE

The address of the primary residence in Canada where the applicant ordinarily resides. (If this is not a private residence please complete the name and establishment information in Section 3)

Unit No. (if applicable)	Street No.	Street Address	
City		Province	Postal Code

MAILING ADDRESS

Check box if mailing address is the same as the **Primary Residence Address** provided above.

Unit No. (if applicable)	Street No.	Street Address	
City		Province	Postal Code

SECTION 2: INDIVIDUAL RESPONSIBLE FOR THE APPLICANT (complete if applicable)

To be completed by the individual who is responsible for the applicant. The responsible individual may act on behalf of the registered client. If the applicant would not like to authorize a person to act on the applicant's behalf, this section may be left blank.

First Name(s)	Middle Name (if applicable)	Last Name
Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone
Email	Fax	

I _____ attest that I am an individual who is responsible for _____.
Name of Responsible Individual *Name of Applicant*
 Responsible Individual Signature _____ Date(mm/dd/yyyy) _____

SECTION 3: RESIDENTS OF SHELTERS, HOSTELS OR SIMILAR INSTITUTIONS (complete if applicable)

To be completed by individuals who ordinarily reside at a places (care home, shelter, hostel or similar institution) in Canada, which provide social services to the applicant. If the applicant ordinarily resides at a dwelling place of permanent residence, this section may be left blank.

Institution Name	Institution Type	
Street No.	Street Address	
City	Province	Postal Code
Phone	Fax	Email

I _____ attest that my institution provides food, lodging or other social services to _____.
Name of Institution's Manager *Name of Applicant*
 Manager's Signature _____ Date(mm/dd/yyyy) _____

