

APPLICATION FORM - All funding must be pre-approved

**Registration Number Office
Use Only**

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Issued by Organization

Recipient

Last Name	First Name	Initial

Street Address

Apt. #

--	--	--

City

Province/State

Postal/Zip Code

--

Country

Area Code

Number

Telephone:

--	--

Fax:

--	--

Birth Date:

--	--	--

DAY

MONTH

YEAR

GENDER

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CHECK ↓

CHECK ↓

Parent

Guardian

Last Name	First Name	Initial

Street Address

Apt. #

--	--	--

City

Province/State

Postal/Zip Code

--

Country

Area Code

Number

Telephone:

--	--

Fax:

--	--

Cell:

--	--

Emergency:

--	--

Email:

--

Requested Program/Therapy

Treatment Dates

--	--	--	--

DAY

MONTH

YEAR

Proof of Registration / Attach Copy

Partial

Full

Uncertain

YES (\$)

NO

Funding Required:

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Parent/Guardian Authorization

Print Name

Signature

Date

Please complete all forms and forward to the Lynn Marles at the address above.

PARENT/GUARDIAN COMMENTS:

Please provide details of the condition of the recipient and expectations of the treatment.

If additional space is required please attach a separate document to the form.

Original Signature Required by Parent/Guardian.

Give a Miracle a Chance respects your privacy.

We protect your personal information and adhere to all legislative requirements in protecting privacy.

We do not rent, sell, or trade mailing lists.

Once completed click to next step

CLICK ↓

[CHECK LIST](#)

85 Elizabeth Street
 Sutton, Ontario
 Canada, L0E 1R0
 Telephone: 1-877-603-9991
 Fax: 1-877-603-9991

www.giveamiracleachance.com



Medical Information

**Registration Number
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CHECK LIST

Recipient		
Last Name	First Name	Initial

Parent		Guardian	
Last Name	First Name	Initial	

Physicians Information

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Last Name First Name Initial

Signature

--	--	--

City Province Postal Code

Cell:

--	--

Area Code Number

Telephone:

--	--

Emergency:

--	--

Fax:

--	--

Email:

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CHECK ↓

Diagnosis	See attached	
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If additional space required please attached a separate sheet.

 Physician's Name
 (Please Print)

 Physician's Signature

 Date

Include Medical Form with the Application Package. Signatures are mandatory. Original, email or faxed copies are accepted.

Contact:

Lynn Marles

e-mail: lynn@giveamiracleachance.com

85 Elizabeth Street
Sutton, Ontario
Canada, L0E 1R0
Telephone: 1-877-603-9991
Fax: 1-877-603-9991

www.giveamiraclechance.com



Audio Visual Release Form

**Registration Number
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CLICK ↓



CHECK ↓

CHECK ↓

Recipient		
Last Name	First Name	Initial

Parent	Guardian
Last Name	First Name
Initial	Initial

I understand that by authorizing this Audio Visual Release form, on behalf of _____
Insert Recipient Name

I am irrevocably releasing the use of any likeness dialogue which has been recorded of _____
for the by Give A Miracle A Chance organization, including its' employees, agents, or servants for any multi media
purpose that could include reproducing it on our web site, or any other printed media associated with the organization,
such as promotions, single images, or as wallpaper.

All audio visual records, recordings, negatives and/or slides together with any prints shall constitute the property
of Give A Miracle A Chance, solely and completely.

Give a Miracle A Chance respects your privacy. We protect your personal information and adhere to all legislative
requirements in protecting your privacy. We do not rent, sell, or trade our mailing lists. We use your personal
information to provide services to keep you informed and up to date on our activities.

PRINT NAME

SIGNATURE

DATE

Please be sure to include this form in your Application Package.

We protect your personal information and adhere to all
legislative requirements
in protecting privacy.

We do not rent, sell, or trade mailing lists.



Memorandum of Agreement

Office Use Only

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CHECK LIST

Recipient		
Last Name	First Name	Initial

	CHECK ↓		CHECK ↓
Parent		Guardian	
Last Name	First Name	Last Name	First Name
Initial	Initial	Initial	Initial

This agreement is made between Give A Miracle A Chance and the Parent/Guardian, and the Recipient including any amendments or termination of the agreement.

The purpose of this agreement is to outline the responsibility, accountability, and general principles for delivering the guarantee of enrollment for the recipient, into the approved program.



Maintain an ongoing and open communication with all parties.



Issues and disputes will be dealt with in a constructive, respective, timely manner between all parties.



Maintain a high level of compliance of confidentiality between the organization, the recipient, and the parent/guardian



Any disputes or discrepancies by the Parent/Guardian are to be addressed in writing directly to the Director of the Organization. Any disputes/discrepancies by the Organization are to be addressed in writing directly to the Parent/Guardian by the Director or Project Sponsor if applicable.



Respective Parent/Guardian will provide blogs, photographs and/or videos to the Organization for the duration of the agreement.



The Organization and the Parent/Guardian will be in compliance of the stated terms and conditions of the agreement at all times.



Upon completion of the therapy program the Organization will transfer funds to the approved program, on behalf of the recipient, providing all conditions of enrollment and eligibility are met as described in the approved agreement.



Upon receipt of final approval Parents/Guardians and Program Administration will be provided confirmation in writing by the organization.



If the Recipient is not registered and approved by said date, funds will be forfeited and provided to another eligible Recipient. The Organization will notify the Parent/Guardian/Recipient 10 days prior to the final registration date, that the registration has not been received and is in jeopardy of being cancelled should we (the Organization) not receive finalization in



In the event that the Recipient will not be attending the program, the Parent/Guardian is responsible to notify the Organization accordingly, in writing, via Registered Mail, Thirty (30) days prior to enrollment date.

Give A Miracle A Chance

Parent / Guardian

 Signature Month / Day / Year
 Lynn Marles, Executive Director

 Signature Month / Day / Year

 Signature Month / Day / Year
Recipient (if over the age of 18)