Name: ________________________ Date: ___________________ CLB : _____

Medical Registration Form

Date: ______________________________

YYYY-MM-DD

First Name: _______________Middle Name: _____________

Last Name: ______________________

Date of birth: ______________________

dd-mm-yyyy

Phone no. ______________________________

Address: __________________________________

City: _________________ Province: _______________

Postal code: ______________________

AHS #: ___________________________

Emergency Contact name: ____________________________

Relation: Friend, Sister, Brother, Mother, Father

Choose one from above: ____________________________

Emergency Contact number: ____________________________