Vancouver Island Persons Living with HIV/AIDS Society (VPWAS)

101-1139 Yates Street
Coast Salish Territory
Victoria, BC V8V 3N2

Member Application for VPWAS Programs and Services

- Confidential-

NEW MEMBER INFORMATION			
Last Name	First	Initial	Date
Street Address			Apartment/Unit
City	Prov		Postal Code
Phone	e-mail		
Date of Birth	I identify my gender as:		
Sero Status HIV+ [ ] HCV+ [ ] HIV/HCV Co-infected [ ]			Since:

VPWAS members are mailed newsletters, program/event information, and annual AGM packages *All mail is sent in discreet, unmarked envelopes		
May we send mail to you at this address	Yes [ ]	No [ ]
May we contact you at this phone number	Yes [ ]	No [ ]
May we contact you at this e-mail	Yes [ ]	No [ ]

ALTERNATE CONTACT INFORMATION (if discretion is required at above contact coordinates)		
Street Address		Apartment/Unit
City	Prov.	Postal Code
Phone	e-mail	
EMERGENCY CONTACT		
Last Name	First	Relationship
Street Address		Apartment/Unit
City	Prov.	Postal Code
Phone		

MANDATORY COMPLETION BY APPLICANT

I, _____ (*Print full name*) hereby apply to the Vancouver Island Persons Living with HIV/AIDS Society (VPWAS) for full voting membership, and all services and benefits provided by the Society.

Signature	Date

VPWAS REPRESENTATIVE

Signature	Date

The Vancouver Island Persons Living With HIV/ AIDS Society (VPWAS) exists to offer compassionate peer support, peer navigation, education and information to all persons living with HIV/AIDS and HIV co-infections.

All information gathered will be kept private and confidential. Your membership information is never shared with any member, organization or government agency without your consent.

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PHYSICIAN CONFIRMATION OF HIV/HCV STATUS - CONFIDENTIAL

MANDATORY COMPLETION BY MEDICAL PRACTITIONER

Medical Practitioner is defined, for the purpose of this form, as:

- ✓ Medical Doctor – a member, in good standing with the BC College of Physicians and Surgeons.
- ✓ An HIV Public Health Nurse – a member, in good standing with the College of Registered Nurses of BC.

I, _____ (*Name of Medical Practitioner*) acknowledge that the Vancouver Island Persons Living with HIV/AIDS Society (VPWAS) relies upon this certification for qualification of the applicant for services and benefits received through the Society.

Being a duly licensed medical practitioner in the Province of British Columbia, I certify that _____ (*Name of Applicant*) is living with **HIV/AIDS [ ] HCV [ ]**.

Address: _____

Phone Number: _____

Signature of Medical Practitioner: _____

[ ] Doctor
[ ] Nurse

Please note that to ensure against fraudulent claims, the Vancouver Island Persons Living with HIV/AIDS Society (VPWAS) may contact your office to confirm this patient's sero-status.

Please initial that phone confirmation is acceptable: [ ]

Date:

DOCTOR'S STAMP