



Association lavalloise
pour la déficience
intellectuelle & le trouble
du spectre de l'autisme

* An evaluation is mandatory to
be a member. Please make an
appointment with us for an
evaluation.*

(Laval association for intellectual disabilities and autism spectrum disorder)

Membership form

Last name : _____

First name : _____

Address : _____

City : _____

Postal code : _____

District: _____

Tel. : Home : (_____) _____ - _____

Office : (_____) _____ - _____

Fax : (_____) _____ - _____

Email : _____

Date of birth: _____

STL number : _____

I am a :

Person living with a disability

Do you live in a residential care facility ?

Yes No

Name of the person responsible

Telephone number: _____

Address, if different:

Do you live with your parents?

Yes No

Or (please check off only one box)

*Please enter below the name of the person
living with an intellectual disability*

Parent

Organization

Friend

Other

FULL NAME:

| | |
|-------------------------------|-----------|
| Person with disability: _____ | \$ |
| Parent: _____ | \$ |
| Residence: _____ | \$ |
| Organization: _____ | \$ |
| TOTAL amount : _____ | \$ |

Donation : _____ \$

(Charity receipt upon request)

Signature : _____

Date : _____

Membership privileges

- ✓ Receive information on activities and services, conferences
- ✓ Support and accompaniment service
- ✓ Special events & outings at reduced cost

MEMBERSHIP FEE

| | |
|--|----------|
| Person with disability | \$ 10,00 |
| Members of extended family | \$ 20,00 |
| Residential care manager | \$ 25,00 |
| Organizations, partners, & associates | \$ 50,00 |

New

Only users using our services must be a member of ALEDIA. Resource managers and parents are no longer required to be a member. Therefore, the information will be sent only to members.