MICROSOFT ONE DRIVE SHARE USB PRINT FOLDER

SHARE LINK EQUALS:

-https://1drv.ms/f/s!ApMWsppIKx8EzxBpY1irGSmIvgIa

SHARE LINK TO ONE DRIVE COPY AND PASTE IS THE SHARE FILE USB PRINT

SET UP TO A USB SEPT 23 FOR THE EASY SETUP TO SHARE FILES FOLDERS DOCUMENTS AND PICTURES TO PRINT. AND TO TRANSFER THINGS LIKE LINKS THROUGH DOCUMENT MICROSOFT WORD OF SHARE LINKS FOR MUSC SPREAD SHEETS {EXCELL: AND POWERPOINT AND PDFS AND MOVIES}

WARNING PASTE SHARE LINKS ABOVE THESE APPLICATION FORMS THESE ARE COPY AND PASTE FORMS FROM ONLINE PDF FOR TYPING AND PRINTING AFTER MODIFIED IN WORD FROM ABW ONLINE

AARON WEST ALL FORM DOCUMENTS SEPERATED BY STARS AS SO WITH 1 RETURN

****

TEXT SIZE 36 TERQUOISE

ACE ACTIVITY CENTER FOR EMPOWERMENT FORMS COPY AND PASTE PLEASE ADD SHARE LINKS OF USB PRINT CLOUD FOLDER OF DOCUMENTS ABOVE THIS HERE SIGNED FORM

*Information is mandatory to obtain a membership Page 1

Activity Centre for Empowerment (A.C.E.) Prince George

BRANCH MEMBERSHIP APPLICATION

Membership Type: Mental Health Service User Date:

*First Name: *Last Name:

*Address: Apt #:

*City: Postal Code:

Telephone: Cell:

Email:

*Birthdate: YY____ MM____ DD____ Would you like to be part of the ACE Birthday club? Yes No

Would you be interested in volunteering at ACE? Yes No

*Emergency Contacts: (One is mandatory)

1. Name: Phone :

Relationship to you:

2. Name: Phone :

Relationship to you:

*Information is mandatory to obtain a membership Page 2

Do you have any allergies or medical conditions that ACE staff should be aware of? (Example: Diabetes, epilepsy, allergy to penicillin) Yes No

If yes please describe condition and current treatment:

Referral Information

Case Manager: Phone:

(Can be social worker/Counsellor or other service provider from Northern Health Mental Health and Addictions Services)

Family Doctor: Phone:

*Psychiatrist: Phone:

*Diagnosis:

*Self Referral: Yes No If no, name of person who referred you: (If yes a further referral may be required.)

Do you have a life skills worker? Yes No

If yes what organization are they from (Example Northern Health, CMHA, BIG, AimHi)

Notes

Activity Center for Empowerment (A.C.E.)

Membership Agreement

*I, have read and agree to abide by the Community Standards of the Activity Centre of Empowerment (A.C.E.).

I release A.C.E. from any liability for injuries to myself, or any damage to personal property, while attending the Centre and participation in any activities organized by the Activity Centre for Empowerment. I understand that information on this for m may be shared with Northern Health, and that by signing the membership I consent to this sharing of my personal information.

Signature of member

Date

Print Name

Name of Staff Accepting Form

Date

Approved By

Date

7

CONFIDENTIAL REFERRAL FORM ACTIVITY CENTER FOR EMPOWERMENT A.C.E.

NAME: _____ PHONE:

ADDRESS:

DOB: _____ PHONE:

EMERGENCY CONTACT: _____ PHONE:

DOCTOR: _____ PHONE:

DSM IV CLASSIFICATIONS:

MEDICATIONS:

History of abusive behaviour? YES _____ NO

SELF _____ OTHERS

Regularly seeing someone at Mental Health and Addiction Services? YES _____ NO

Currently using alcohol/street drugs? YES _____ NO

Any physical limitations? YES _____ NO

Specifics:

Smoker? YES _____ NO

If smoker would they like help to quite? YES _____ NO

Key resource people (family, church group etc)

IPT Team # _____ or MHAS Specialized Service s Team

Name of Team Member completing form _____ (print please)

_____ (signature)

Date: _____