



HOCKEY CANADA INJURY REPORT

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See reverse for mailing address

Forms must be filled out in full or form will be returned. This form must be completed for each case where an injury is sustained by a player, spectator or any other person at a sanctioned hockey activity

CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE. DATE OF INJURY: ___/___/___ MANDATORY
Mo. Day Yr.

INJURED PARTICIPANT: Player Team Official Game Official Spectator

Name: _____ Birthdate: ___/___/___ Sex: M F
Mo. Day Yr.

Address: _____

City / Town: _____ Province: _____ Postal Code: _____ Phone: (___) _____

Parent / Guardian: _____

DIVISION Initiation Novice Atom
 Pee-wee Bantam Midget Juvenile
 Junior Collegial/University

CATEGORY
 AAA A BB CC Senior Adult Rec.
 AA B C Major Junior Espoir Other _____

BODY PART INJURED

Head <input type="checkbox"/> Face <input type="checkbox"/> Skull <input type="checkbox"/> Eye Area <input type="checkbox"/> Throat <input type="checkbox"/> Dental	Back <input type="checkbox"/> Lower <input type="checkbox"/> Neck <input type="checkbox"/> Upper	Trunk <input type="checkbox"/> Abdomen <input type="checkbox"/> Ribs <input type="checkbox"/> Chest
Arm: <input type="checkbox"/> Left <input type="checkbox"/> Collarbone <input type="checkbox"/> Right <input type="checkbox"/> Elbow <input type="checkbox"/> Shoulder <input type="checkbox"/> Hand/Finger <input type="checkbox"/> Upper arm <input type="checkbox"/> Forearm/Wrist	Leg: <input type="checkbox"/> Left <input type="checkbox"/> Knee <input type="checkbox"/> Right <input type="checkbox"/> Toe <input type="checkbox"/> Shin <input type="checkbox"/> Thigh <input type="checkbox"/> Other <input type="checkbox"/> Foot	Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> Groin

NATURE OF CONDITION

Concussion Laceration Fracture
 Sprain Strain Contusion
 Dislocation Separation Internal Organ Injury

ON-SITE CARE

On-Site Care Only Refused Care

Sent to Hospital by: Ambulance Car

INJURY CONDITIONS

Name of arena / location: _____

Exhibition/Regular Season Period #2
 Playoffs/Tournament Period #3
 Practice Overtime: _____
 Try-outs Dry Land Training
 Other Gradual Onset
 Warm-up Other Sport
 Period #1 Other: _____

CAUSE OF INJURY

Hit by Puck
 Collision with Boards
 Non-Contact Injury
 Hit by Stick
 Collision on Open Ice
 Collision with Opponent
 Fall on Ice
 Checked from Behind
 Collision with Net
 Fight
 Blindsiding

Was the injured player in the correct league and level for their age group?
 Yes No

Was this a sanctioned Hockey Canada activity?
 Yes No

LOCATION

Defensive Zone Offensive Zone Neutral Zone
 Behind the Net 3 ft. from Boards Spectator Area
 Parking Lot Dressing Room Bench
 Other: _____

WEARING WHEN INJURED

Full Face Mask
 Intra-Oral Mouth Guard
 Half Face Shield/Visor
 Throat Protector
 Helmet/No Face Shield
 No Helmet/No Face Shield
 Short Gloves
 Long Gloves

ADDITIONAL INFORMATION

Has the player sustained this injury before? Yes No

If "Yes" how long ago _____

Was a penalty called as a result of the incident? Yes No

Estimated absence from hockey?
 1 week 1-3 weeks 3+ weeks

DESCRIBE HOW ACCIDENT HAPPENED

(Attach page if necessary)

SIGNATURE (MANDATORY)

I hereby authorize any Health Care Facility, Physician, Dentist or other person who has attended or examined me/my child, to furnish Hockey Canada any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all dental, hospital, and medical records. A photo static/electronic copy of this authorization shall be considered as effective and valid as the original.

Signed: _____

(Parent/Guardian if under 18 years of age)

Date: _____

TEAM INFORMATION

(To be completed by a Team Official)

Association: _____

Team Name: _____

Team Official (Print): _____

Team Official Position: _____

Signature: _____

Date: _____

HEALTH INSURANCE INFORMATION

THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED

Occupation: Employed Full-time Employed Part-time
 Unemployed Full-Time Student

Employer (If minor, list parent's employer): _____

1. Do you have provincial health coverage? Yes No Province: _____

2. Do you have other insurance? Yes No
(IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.)

3. Has a claim been submitted? Yes No
(IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATIONS OF BENEFITS.)

Make Claim Payable To: Injured Person Parent Team Other: _____

Branch APPROVAL



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PHYSICIAN'S STATEMENT

Physician: _____ Address: _____ Tel: (____) _____

Name of Hospital / Clinic: _____ Address: _____

Nature of Injury: _____ Date of First Attendance: _____

_____ Claimant will be totally disabled:

_____ From: _____ To: _____

_____ Is the injury permanent and irrecoverable? No Yes

Give the details of injury (degree): _____

Prognosis for recovery: _____

Did any disease or previous injury contribute to the current injury? No Yes (describe): _____

Was the claimant hospitalized? No Yes (give hospital name, address and date admitted): _____

Names and addresses of other physicians or surgeons, if any, who attended claimant: _____

I certify that the above information is correct and to the best of my knowledge,

Signed: _____ Date: _____

DENTIST STATEMENT

Limits of coverage: \$1,250 per tooth, \$2,500 per accident
Treatment must be completed within 52 weeks of accident

UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.

Patient		
Last name		Given name
Address		
City / Town	Province	Postal Code

Dentist
PHONE NO

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM / HER

SIGNATURE OF SUBSCRIBER

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION.

DUPLICATE FORM

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.

I ACKNOWLEDGE THAT THE TOTAL FEE OF \$_____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR THE SERVICES RENDERED.

I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

SIGNATURE OF (PATIENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY / MO. / YR.	PROCEDURE	INITIAL TOOTH CODE	TOOTH SURFACE	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE & OE. NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.	TOTAL FEE SUBMITTED
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