INJURY REPORT

PAGE 1/2

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: __/__/__ (Mo. Day Yr.)

INJURED PARTICIPANT: ☐ Player ☐ Team Official ☐ Game Official ☐ Spectator

Name: _____ Birthdate: __/__/__ (Mo. Day Yr.) Sex: ☐ M ☐ F

Address: _____

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

Parent / Guardian: _____ Email: _____

DIVISION

☐ Initiation ☐ Novice ☐ Atom ☐ Peewee
☐ Bantam ☐ Midget ☐ Juvenile ☐ Junior

SKILL LEVEL

☐ AAA ☐ A ☐ BB ☐ CC ☐ DD ☐ House ☐ Minor Junior ☐ Adult Rec.
☐ AA ☐ B ☐ C ☐ D ☐ E ☐ Major Junior ☐ Senior ☐ Other _____

BODY PART INJURED

Head ☐ Face ☐ Skull ☐ Eye Area ☐ Throat ☐ Dental

Back ☐ Lower ☐ Neck ☐ Upper

Trunk ☐ Abdomen ☐ Ribs ☐ Chest

Arm: ☐ Left ☐ Right ☐ Collarbone ☐ Elbow ☐ Shoulder ☐ Hand/Finger ☐ Upper arm ☐ Forearm/Wrist

Leg: ☐ Left ☐ Right ☐ Knee ☐ Toe ☐ Shin ☐ Thigh ☐ Other ☐ Foot

Pelvis ☐ Hip ☐ 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)

_____
_____
_____
_____
_____
_____

I hereby authorize any Health Care Facility, Physician, Dentist or other person who has attended or examined me, 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: _____

LEAGUE INFORMATION

(To be completed by a League Manager)

League: _____

Team Name: _____

League Manager: _____

Facility: _____

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 ☐ Self Employed ☐ 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 ☐ Team ☐ Other: _____

IMPORTANT

- ALL REIMBURSEMENT CLAIMS MUST INCLUDE ORIGINAL RECEIPTS
- LOSS OF INCOME BENEFIT REQUIRES:
  - Employee Cheque Stub
  - T4
  - Letter from doctor or employer indicating time period off work

Mail completed form to: Hockey Canada
801 King Edward Ave, Suite N204
Ottawa, ON K1N 6N5

NOTE: Claims will take 6-8 weeks to process.

INJURY REPORT

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

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 ACKNOWLEGDE 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	

Mail completed form to: Hockey Canada
801 King Edward Ave, Suite N204
Ottawa, ON K1N 6N5

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