HOCKEY CANADA INJURY REPORT

PAGE 1/2

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 INJURY. INJURY DATE: ____/____/____

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

Name: _____ Birthdate: ____/____/____ Sex: (M) (F)

Address: _____ City/ Town _____

Province: _____ Postal Code: _____ Phone: (_____) _____

Parent/Guardian: _____

DIVISION:

☐Initiation ☐Novice ☐Atom ☐PeeWee
☐Bantam ☐Midget ☐Juvenile

CATEGORY:

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

BODY PART INJURED:

Head		**Back**	**Trunk**	**Arm**	**Left**	**Right**	**Pelvis**	**Leg**	**Left**	**Right**
☐Eye Area	☐Face	☐Neck	☐Ribs	☐Shoulder	☐	☐Hand/Finger	☐Hip	☐Thigh	☐	☐Foot
☐Throat	☐Dental	☐Upper	☐Chest	☐Upperarm	☐	☐Forearm/Wrist	☐Groin	☐Knee	☐	☐Toe
☐Skull		☐Lower	☐Abdomen	☐Elbow	☐	☐Collarbone		☐Shin	☐	☐Other

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** ☐**Playoffs/Tournament** ☐**Practice** ☐**Try-outs** ☐**Other**

☐Warm-up ☐Period #1 ☐Period #2: ☐Period #3 ☐Overtime # _____
☐Dry Land Training ☐Gradual Onset ☐Other Sport ☐Other: _____

Was the injured player in the correct league and level for their age group? ☐**Yes** ☐**No**
Was this a sanctioned Hockey Canada hockey activity? ☐**Yes** ☐**No**

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

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 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, Phyician, 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 photostatic/electronic copy of this authorization shall be considered as effective and valid as the original.

Signed: _____ Date: _____
(Parent/Guardian if under 18 years of age)

TEAM INFORMATION: (To be completed by a Team Official)

Association: _____ Team Name : _____

Team Official (Print): _____ Team Official Position: _____

Signature: _____ Date: _____

HEALTH INSURANCE INFORMATION:

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 explanation of benefits)

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

Branch APPROVAL

HOCKEY CANADA 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 details of injury (degree) : _____

_____

Prognosis for recovery : _____

_____

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

_____

Was 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 to the best of my knowledge,

Signed: _____ Date: _____

DENTIST'S 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.

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

PATIENT
LAST NAME GIVEN NAME
_____
ADDRESS APT.
_____
CITY PROV. POSTAL CODE

DENTIST
PHONE NO.

_____
SIGNATURE OF SUBSCRIBER

FOR DENTIST'S 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 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