



See reverse for mailing address

HOCKEY CANADA INJURY REPORT



CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE: ____/____/____
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 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: * visit the Hockey Canada web-site for an optional questionnaire *

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

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): _____

- Do you have provincial health coverage? Yes No Province: _____
- Do you have other insurance? Yes No (IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.)
- 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

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 the best of my knowledge,

Signed: _____ Date: _____

DENTIST STATEMENT

Limits of coverage: \$1,000 per tooth, \$2,000 per accident
Treatment must be completed within 52 weeks of accident

P LAST NAME GIVEN NAME		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
A			
T		PHONE NO.	SIGNATURE OF SUBSCRIBER _____
I ADDRESS APT.			
E			
N			
T CITY PROV. POSTAL CODE			

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

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.

DUPLICATE FORM

SIGNATURE OF (PATIENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY / MO. / YR.	PROCEDURE	INITIAL TOOTH CHARGE	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.

TOTAL FEE SUBMITTED

NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.

Mail completed form to:
ALLIANCE Hockey
71 Albert Street Stratford, ON N5A 3K2
Tel : 519-273-7209 Fax : 519-273-2114