

# HOCKEY CANADA INJURY REPORT



**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: \_\_\_\_\_

*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.*

**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 \***

- |   |                                |                                  |                                   |  |                                |                                |                               |                               |                                |
|---|--------------------------------|----------------------------------|-----------------------------------|--|--------------------------------|--------------------------------|-------------------------------|-------------------------------|--------------------------------|
| <b>Head</b>   | <b>Back</b>                    | <b>Trunk</b>                     | <b>Arm</b>                        | <input type="checkbox"/> Left          | <input type="checkbox"/> Right | <b>Pelvis</b>                  | <b>Leg</b>                    | <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 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, 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:**

- 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**

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

FOR DENTIST'S USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, 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 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 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**