HOCKEY TRAINERS CERTIFICATION PROGRAM RETURN TO PLAY

________________________________
Name of Player

is able to return to play following injuries sustained on

________________________________
Date

Considerations /restrictions with respect to return to play:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

________________________________  __________________________
Name of Treating Physician     Signature

Date: _________________

This information is strictly confidential and will only be used to assist in the player’s safe return to play. All records will be returned to the player.

Disclaimer: Personal information used, disclosed, secured or retained will be held solely for the purposes for which we collected it and in accordance with the National Privacy Principles contained in the Personal Information Protection and Electronic Documents Act.