See reverse for mailing address

HOCKEY CANADA INJURY REPORT

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: * visit the Hockey Canada web-site for an optional questionnaire *

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

Back: ☐ Neck ☐ Upper ☐ Lower

Trunk: ☐ Ribs ☐ Chest ☐ Abdomen

Arm ☐ **Left** ☐ **Right**: ☐ Shoulder ☐ Upperarm ☐ Elbow ☐ Hand/Finger ☐ Forearm/Wrist ☐ Collarbone

Pelvis: ☐ Hip ☐ Groin

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

ADDITONAL 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:
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): ______________________________
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: $1,000 per tooth, $2,000 per accident
Treatment must be completed within 52 weeks of accident

UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.

PATIENT

LAST NAME GIVEN NAME

____

ADDRESS APT.

____

CITY PROV. 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'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

Mail completed form to:

Ontario Women's Hockey Association
5155 Spectrum Way, Building #3, Mississauga ON L4W 5A1
Phone: 905-282-9980 Fax: 905-282-9982