



# 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:**

**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.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER
P A T I E N T L A S T N A M E G I V E N N A M E	D E N T I S T	
I A D D R E S S A P T.	PHONE NO.	SIGNATURE OF SUBSCRIBER
N E A D D R E S S		
T C I T Y P R O V I N C E P O S T A L C O D E		

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.

**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  
 150 Huron St., Stratford, ON N5A 5S8  
 Phone: 519-273-7209 Fax: 519-273-2114**