



See reverse for mailing address

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.

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: _____

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 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:
 Hockey Newfoundland and Labrador
 15 A High Street, PO Box 176, Grand Falls-Windsor, NF A2A 2J4
 Phone: 709-489-5512 Fax: 709-489-2273**