



See reverse for mailing address

# HOCKEY CANADA INJURY REPORT



CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Yr.

INJURED PARTICIPANT:  Player  Team Official  Game Official  Spectator  
Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: (M) (F)  
Mo. Day Yr.

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 \***

- |   |   |  |   |                                |   |   |  |  |                                |
|---|---|--|---|--------------------------------|---|---|--|--|--------------------------------|
| <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 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 a 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): \_\_\_\_\_

- Do you have provincial health coverage?  Yes  No Province: \_\_\_\_\_
- Do you have other insurance?  Yes  No (IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.)
- Has a claim been submitted?  Yes  No (IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATIONS 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 the details of injury (degree): \_\_\_\_\_

Prognosis for recovery: \_\_\_\_\_

Did any disease or previous injury contribute to the current injury?  No  Yes (describe): \_\_\_\_\_

Was the 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 and the best of my knowledge,

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIANOGNIS 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 THE 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 CHARGE	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.	<b>TOTAL FEE SUBMITTED</b>
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NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.

**Mail completed form to:**  
**Hockey PEI**  
**PO Box 302, Charlottetown, PE C1A 7K7**  
**Phone: 902-368-4334 Fax: 902-368-4337**