

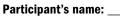
## **HOCKEY CANADA INJURY REPORT**



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.	INJURED PARTICIPANT: Name: Address: City / Town:	Player Team Off	Province: Postal (	Mo. Day Yr. Spectator _ Birthdate:// Mo. Day Yr.  Code: Phone: (	)			
hockey activity.       Parent / Guardian:       Email Address:         AGE DIVISION       Email Address:       CATEGORY         Under-7       Under-11       Under-13       Adult Rec         Under-15       Under-18       Under-21       Junior       Senior								
Upper arm U Collarbone Co Elbow El Hand/Finger Ha	Leg:       t     Left     Righ       houlder     Shin     S       pper arm     Knee     K       ollarbone     Toe     To       bow     Thigh     Th	nin Face Chest nee Throat Ribs	Back: en Neck Lower Upper Groin Concuss Sprain Dislocat	Strain Contus	sion al Organ Injury			
INJURY COND         Name of arena/locatio         Exhibition/Regular         Playoffs/Tournamer         Practice         Try-outs         Other         Warm-up         Period #1	Season	ct league and level for Ho age group? s □ No CATION efensive Zone □ Offensive Zo ehind the Net □ 3 ft. from B	oards 🗆 Spectator Area					
□ Helmet/No Face Shield       before?       □ Yes         □ No Helmet/No Face Shield       If "Yes" how long ag         □ Intra-Oral Mouth Guard       Was a penalty calle incident?         □ Half Face Shield/Visor       □ Throat Protector         □ Chroat Olimeter       Estimated absence		ATION r sustained this injury es	DESCRIBE HOW INCIDENT HAPPE (Attached additional page if necessary)	<b>PPENED</b> Physician, Dentist or other person who has attended or examined me/my child, to furnish				
Team Official Position:	Team Official)	HEALTH INSURANCE INFORMATION       MEMBER         THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED       Occupation:       Employed Full-time       Employed Part-time         Occupation:       Employed Full-time       Employed Part-time       Employed Part-time       APPROVAL         Employer (If minor, list parent's employer):						



## HOCKEY CANADA INJURY REPORT





PHYSICIAN'S STAT		л	ddroce:		Tab	( )	
Physician: / Name of Hospital / Clinic:					Tel: ()		
ature of Injury:			Date of Firs Claimant wi From:	Address: Date of First Attendance: Claimant will be totally disabled: From: To:			
ive the details of injury (deg	gree):			Is the injury permanent and irrecoverable? ☐ No ☐ Yes Prognosis for recovery:			
Did any disease or previous injury contribute to the current injury? No Yes (describe):			Was the claimant hospital (give hospital name, addr				
lames and addresses of othe	er physicians or surge	ons, if any, who a	attended claimant:				
certify that the above inform			knowledge, Date:		_		
DENTIST STATEME mits of coverage: \$1,250 per too e completed within 52 weeks of	NT oth, \$3,000 per accident	t. Treatment must	UNIQUE NO. SPEC.	PATIENT'S OFFICIA	AL ACCOUNT NO.		
Patient			Dentist			I hereby assign my benefits payable from this claim directly to the named dentist and authorize payment directly to him / her	
Last name Given name							
Address City / Town Province Postal Code			Phone No			SIGNATURE OF SUBSCRIBER	
For dentist use only – for ad procedures or special consid		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.					
DUPLICATE FORM			SIGNATURE OF (PAT		OFFICE VERI	FICATION	
DATE OF SERVICE MO. / DAY / YR.	PROCEDURE	INITIAL TOOTH CODE	TOOTH SURFACE	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE	
This is an accurate statemen NOTE: All benefits subject to insi					TOTAL FEE SUBM	IITTED	
209 CH	<b>Ckey P.E.I.</b> 9 - 40 Enman Cres( Arlottetown, Pe E 1e6	CENI	<b>il:</b> info@hockeypei. 902-368-4334	com			