

Date: _

HOCKEY CANADA INJURY REPORT



CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE. See reverse for mailing address. **INJURED PARTICIPANT:** Player Team Official Game Official Spectator Forms must be filled out in full or form will be Birthdate: ___/__/__ Mo. Day Yr. Name: _ Gender: M returned. This form must be completed for each case where an injury is Address: sustained by a player. ______ Province: ______ Postal Code: ______ Phone: (____) _____ spectator or any other City / Town: person at a sanctioned _____ Email Address: ____ hockey activity. Parent / Guardian: **AGE DIVISION CATEGORY** Under-7 Under-9 Under-13 Adult Rec BB Under-11 AAA Α CC DD House Minor Junior Under-15 Under-18 Under-21 Junior Senior В AA **Major Junior** Other **BODY PART INJURED** NATURE OF CONDITION Head: Arm: Leg: Trunk: Back: Concussion Laceration Fracture Right Left Eve Area Abdomen Neck Sprain Strain Contusion Left Right Face Chest Dislocation Internal Organ Injury Shoulder Shoulder Shin Shin Lower Separation Throat Ribs Upper Upper arm Upper arm Knee Knee Skull Pelvis: Collarbone Collarbone Toe Toe ON-SITE CARE Groin Dental Elbow Elbow Thigh Thigh Hip On-Site Care Only Refused Care Hand/Finger Hand/Finger Foot Foot Other: Forearm/Wrist Forearm/Wrist Sent to Hospital by: **Ambulance** Car Was the injured player in the Was this a sanctioned **INJURY CONDITIONS CAUSE OF INJURY** correct league and level for Hockey Canada activity? Hit by Puck Name of arena/location: their age group? ☐ Yes ☐ No Collision with Boards ☐ Yes ☐ No Non-Contact Injury ☐ Exhibition/Regular Season ☐ Period #2 Hit by Stick ☐ Playoffs/Tournament ☐ Period #3 Collision on Open Ice Collision with Opponent ☐ Practice ☐ Overtime: LOCATION Fall on Ice ☐ Try-outs ☐ Dry Land Training ☐ Defensive Zone ☐ Offensive Zone ☐ Neutral Zone Checked from Behind ☐ Other ☐ Gradual Onset ☐ Behind the Net ☐ 3 ft. from Boards ☐ Spectator Area Collision with Net ☐ Other Sport ☐ Warm-up ☐ Dressing Room ☐ Bench ☐ Parking Lot Fight ☐ Period #1 ☐ Other: _ ☐ Other: ___ Blindsiding I hereby authorize any Health Care Facility, WEARING ADDITIONAL DESCRIBE HOW Physician, Dentist or other person who has WHEN INJURED INFORMATION INCIDENT HAPPENED attended or examined me/my child, to furnish (Attached additional page if necessary) Has the player sustained this injury Hockey Canada any and all information with ☐ Full Face Mask respect to any illness or injury, medical history, before? ☐ Yes ☐ No ☐ Helmet/No Face Shield consultation, prescriptions or treatment and copies ☐ No Helmet/No Face Shield If "Yes" how long ago? of all dental, hospital, and medical records. A photo ☐ Intra-Oral Mouth Guard Was a penalty called as a result of the static/electronic copy of this authorization shall be ☐ Half Face Shield/Visor considered as effective and valid as the original. incident? ☐ Yes ☐ No ☐ Throat Protector Estimated absence from hockey? ☐ Short Gloves (Parent/Guardian if under 18 years of age) \square 1 week \square 1-3 weeks \square 3+ weeks ☐ Long Gloves **MEMBER TEAM INFORMATION HEALTH INSURANCE INFORMATION APPROVAL** THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED (To be completed by a Team Official) ☐ Employed Full-time ☐ Employed Part-time Occupation: ☐ Unemployed ☐ Full-Time Student Association: Employer (If minor, list parent's employer): _ Team Name:__ 1. Do you have provincial health coverage? ☐ Yes ☐ No Province: Team Official (Print): 2. Do you have other insurance? ☐ Yes ☐ No (IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.) Team Official Position: 3. Has a claim been submitted? ☐ Yes ☐ No Signature: _____ (IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATIONS OF BENEFITS.)

Make Claim Payable To: Injured Person Parent Team Other:



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Participant's name:

PHYSICIAN'S STATE	MENT					
Physician:			dress: Tel: ())
Name of Hospital / Clinic:			Address:			
Nature of Injury:			Date of First	Date of First Attendance:		
	Claimant will be totally disabled:			ed:		
				From:		To:
				Is the inju	iry permanent and	l irrecoverable? □ No □ Yes
Give the details of injury (degree		Prognosis fo	Prognosis for recovery:			
Did any disease or previous inju		Was the claimant hospitalized? No Yes				
No Yes (describe):	(give hospital name, addre			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 to the best of my knowledge,						
Signed: Date:						
DENTIET CTATEMEN	·					
DENTIST STATEMEN Limits of coverage: \$1,250 per tooth	. Treatment must	UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.				
Limits of coverage: \$1,250 per tooth, \$3,000 per accident. Treatment must be completed within 52 weeks of accident. (Effective September 1st, 2018)						
Patient			Dentist I hereby assign my benefits payable from this claim directly to the named dentist and authorize			
Last name Given name						payment directly to him / her
Address						
City / Town P	Discount of the second of the			CIONATURE OF CURCORIRER		
City / Town Province Postal Code			Phone No			SIGNATURE OF SUBSCRIBER
For dentist use only - for addi	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.					
procedures or special conside						
			I authorize release o	f the information co	ontained in this cl	aim form to my insuring
DUPLICATE FORM □	company/plan admi	nistrator.				
	SIGNATURE OF (PATIENT/GUARDIAN) OFFICE VERIFICATION					
DATE OF SERVICE		INITIAL TOOTH				
MO. / DAY / YR.	PROCEDURE	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 NEW BRUNSWICK

P.O BOX 456 TEL: 506-453-0089 FREDERICTON, NB FAX: 506-453-0868 E3B 4Z9 HNB.CA