



# 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.

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

**INJURED PARTICIPANT:** Player Team Official Game Official Spectator

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Gender: M F  
Mo. Day Yr.

Address: \_\_\_\_\_

City / Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: ( \_\_\_ ) \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_ Email Address: \_\_\_\_\_

## AGE DIVISION

Under-7 Under-9 Under-11 Under-13 Adult Rec  
Under-15 Under-18 Under-21 Junior Senior

## CATEGORY

AAA A BB CC DD House Minor Junior  
AA B C D E Major Junior Other \_\_\_\_\_

## BODY PART INJURED

Arm:		Leg:		Head:	Trunk:	Back:
Left	Right	Left	Right	Eye Area	Abdomen	Neck
Shoulder	Shoulder	Shin	Shin	Face	Chest	Lower
Upper arm	Upper arm	Knee	Knee	Throat	Ribs	Upper
Collarbone	Collarbone	Toe	Toe	Skull	Pelvis:	
Elbow	Elbow	Thigh	Thigh	Dental		Hip
Hand/Finger	Hand/Finger	Foot	Foot	Other: _____		
Forearm/Wrist	Forearm/Wrist					

## 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  Period #2  
 Playoffs/Tournament  Period #3  
 Practice  Overtime: \_\_\_\_\_  
 Try-outs  Dry Land Training  
 Other  Gradual Onset  
 Warm-up  Other Sport  
 Period #1  Other: \_\_\_\_\_

## 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

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

## 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  
 Helmet/No Face Shield  
 No Helmet/No Face Shield  
 Intra-Oral Mouth Guard  
 Half Face Shield/Visor  
 Throat Protector  
 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 INCIDENT HAPPENED

(Attached additional 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 photo static/electronic copy of this authorization shall be considered as effective and valid as the original.

Signed: \_\_\_\_\_  
 (Parent/Guardian if under 18 years of age)  
 Date: \_\_\_\_\_

## 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 EXPLANATIONS OF BENEFITS.)

Make Claim Payable To: Injured Person Parent Team Other: \_\_\_\_\_

## MEMBER APPROVAL



# HOCKEY CANADA INJURY REPORT



Participant's name: \_\_\_\_\_

## 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 to the best of my knowledge,

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

## DENTIST STATEMENT

Limits of coverage: \$1,250 per tooth, \$3,000 per accident. Treatment must be completed within 52 weeks of accident. (Effective September 1st, 2018)

UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.

<b>Patient</b>		
_____	_____	
Last name	Given name	
_____		
Address		
_____		
City / Town	Province	Postal Code
_____	_____	_____

<b>Dentist</b>
_____
_____
_____
Phone No
_____

I hereby assign my benefits payable from this claim directly to the named dentist and authorize payment directly to him / her

\_\_\_\_\_

SIGNATURE OF SUBSCRIBER

For dentist use only – for additional information, diagnosis, procedures 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 MO. / DAY / 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 CANADA**  
 Suite 201      Tel: 1-888-777-2192  
 151 Canada Olympic Road SW      Fax: 1-403-777-3635  
 Calgary, AB T3B 6B7      www.hockeycanada.ca