



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 W 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:
 SHA
 2-575 Park St., Regina, SK S4N 5B2
 Phone: 306-789-5101 Fax: 306-789-6112**