See reverse for mailing address

HOCKEY CANADA INJURY REPORT

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 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** ☐ **Left** ☐ **Right**	**Pelvis**	**Leg** ☐ **Left** ☐ **Right**
☐ Eye Area ☐ Face	☐ Neck	☐ Ribs	☐ Shoulder ☐ Hand/Finger	☐ Hip	☐ Thigh ☐ Foot
☐ Throat ☐ Dental	☐ Upper	☐ Chest	☐ Upperarm ☐ Forearm/Wrist	☐ Groin	☐ Knee ☐ Toe
☐ Skull	☐ Lower	☐ Abdomen	☐ Elbow ☐ Collarbone		☐ Shin ☐ 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

ADDITONAL 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, Phyician, 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
PATIENT LAST NAME GIVEN NAME _____ ADDRESS APT. _____ CITY PROV. POSTAL CODE	DENTIST PHONE NO.	_____ SIGNATURE OF SUBSCRIBER

FOR DENTIST'S 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 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 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.

NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.

TOTAL FEE SUBMITTED

Mail completed form to:
Mississauga Hockey League
3065 Ridgeway Drive, Unit 34, Mississauga, ON L5L 5M6
Phone: 905-607-1118 Fax: 905-607-1124