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 THE INJURY DATE. DATE OF INJURY: __/__/__ (Mo. Day Yr.)

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

Name: _____ Birthdate: __/__/__ (Mo. Day Yr.) Sex: ☐ M ☐ F

Address: _____

City / Town: _____ Province: _____ Postal Code: _____ Phone: (___) _____

Parent / Guardian: _____ Email Address: _____

DIVISION

☐ Initiation ☐ Novice ☐ Atom ☐ Peewee
☐ Bantam ☐ Midget ☐ Juvenile ☐ Junior

CATEGORY

☐ AAA ☐ A ☐ BB ☐ CC ☐ DD ☐ House ☐ Minor Junior ☐ Adult Rec.
☐ AA ☐ B ☐ C ☐ D ☐ E ☐ Major Junior ☐ Senior ☐ Other _____

BODY PART INJURED

Head ☐ Face ☐ Skull ☐ Eye Area ☐ Throat ☐ Dental

Back ☐ Lower ☐ Neck ☐ Upper

Trunk ☐ Abdomen ☐ Ribs ☐ Chest

Arm: ☐ Left ☐ Right ☐ Collarbone ☐ Elbow ☐ Shoulder ☐ Hand/Finger ☐ Upper arm ☐ Forearm/Wrist

Leg: ☐ Left ☐ Right ☐ Knee ☐ Toe ☐ Shin ☐ Thigh ☐ Other ☐ Foot

Pelvis ☐ Hip ☐ Groin

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
☐ 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 a 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 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.

Patient

_____
Last name Given name

_____
Address

_____
City / Town Province Postal Code

Dentist

_____
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 ACKNOWLEGDE 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 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	

Scan and Email to: **BC HOCKEY**
info@bchockey.net or
Fax 250-652-4536