



# HOCKEY CANADA INJURY REPORT

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ONTARIO WOMEN'S HOCKEY ASSOCIATION

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: \_\_\_/\_\_\_/\_\_\_ Sex:  M  F  
Mo. Day Yr.

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

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

Parent / Guardian: \_\_\_\_\_

## 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

<b>Head</b> <input type="checkbox"/> Eye Area <input type="checkbox"/> Throat <input type="checkbox"/> Dental	<input type="checkbox"/> Face <input type="checkbox"/> Skull	<b>Back</b> <input type="checkbox"/> Neck <input type="checkbox"/> Upper	<input type="checkbox"/> Lower	<b>Trunk</b> <input type="checkbox"/> Ribs <input type="checkbox"/> Chest	<input type="checkbox"/> Abdomen
<b>Arm:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Collarbone <input type="checkbox"/> Elbow	<b>Leg:</b> <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Knee <input type="checkbox"/> Toe	<b>Pelvis</b>	<input type="checkbox"/> Hip <input type="checkbox"/> Groin
<input type="checkbox"/> Shoulder <input type="checkbox"/> Hand/Finger	<input type="checkbox"/> Upper arm <input type="checkbox"/> Forearm/Wrist	<input type="checkbox"/> Shin <input type="checkbox"/> Thigh	<input type="checkbox"/> Other <input type="checkbox"/> Foot		

## 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: \_\_\_\_\_

Branch APPROVAL



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## 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, \$2,500 per accident  
 Treatment must be completed within 52 weeks of accident

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

<p><b>Patient</b></p> <p>_____</p> <p>Last name _____ Given name _____</p> <p>_____</p> <p>Address _____</p> <p>_____</p> <p>City / Town _____ Province _____ Postal Code _____</p>	<p><b>Dentist</b></p> <p>_____</p> <p>_____</p> <p>PHONE NO _____</p>	<p>I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM / HER</p> <p>_____</p> <p>SIGNATURE OF SUBSCRIBER</p>
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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 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.