



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

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

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

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

## DIVISION

- Initiation  Novice  Atom  Pee wee
- 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><br><input type="checkbox"/> Face <input type="checkbox"/> Skull<br><input type="checkbox"/> Eye Area <input type="checkbox"/> Throat <input type="checkbox"/> Dental  | <b>Back</b><br><input type="checkbox"/> Lower<br><input type="checkbox"/> Neck <input type="checkbox"/> Upper  | <b>Trunk</b><br><input type="checkbox"/> Abdomen<br><input type="checkbox"/> Ribs <input type="checkbox"/> Chest |
| <b>Arm:</b> <input type="checkbox"/> Left <input type="checkbox"/> Collarbone<br><input type="checkbox"/> Right <input type="checkbox"/> Elbow<br><input type="checkbox"/> Shoulder <input type="checkbox"/> Hand/Finger<br><input type="checkbox"/> Upper arm <input type="checkbox"/> Forearm/Wrist | <b>Leg:</b> <input type="checkbox"/> Left <input type="checkbox"/> Knee<br><input type="checkbox"/> Right <input type="checkbox"/> Toe<br><input type="checkbox"/> Shin <input type="checkbox"/> Thigh<br><input type="checkbox"/> Other <input type="checkbox"/> Foot | <b>Pelvis</b><br><input type="checkbox"/> Hip<br><input type="checkbox"/> 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 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<br>DAY / MO. / YR. | PROCEDURE | INITIAL TOOTH<br>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