HOCKEY CANADA INJURY REPORT

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: __/__/__ (Mo. Day Yr.) Gender: ☐M ☐F

Address: _____

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

Parent / Guardian: _____ Email Address: _____

AGE DIVISION

☐Under-7 ☐Under-9 ☐Under-11 ☐Under-13 ☐Adult Rec
☐Under-15 ☐Under-18 ☐Under-21 ☐Junior ☐Senior

CATEGORY

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

BODY PART INJURED

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

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
☐ Helmet/No Face Shield
☐ No Helmet/No Face Shield
☐ Intra-Oral Mouth Guard
☐ Half Face Shield/Visor
☐ Throat Protector
☐ 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 INCIDENT HAPPENED

(Attached additional 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 MO. / DAY / 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:

HOCKEY NOVA SCOTIA
259 COMMODORE DRIVE
DARTMOUTH, NS
B3B 0M1

TEL: 902-454-9400
FAX: 902-454-3883
HOCKEYNOVASCOTIA.CA