	H	0	CKE	YO		A IN. AGE 1/2	JL	JRY R	EPORT	CANADA	
See reverse for mailing	CLAIM	CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE. DATE OF INJURY:/									
address Forms must be filled	Mo. Day Yr. INJURED PARTICIPANT: Player Team Official Game Official Spectator										
out in full or form will be returned. This form must								-	e:// Se	ex: 🗆 M 🗆 F	
be completed for each case where an injury is									Mo. Day Yr.		
sustained by a player, spectator or any other									Phone: (_)	
person at a sanctioned hockey activity								100tal 00de	i none. (
	Tarcin	. / u			٦٢						
DIVISION	ice □, get □.					⊐вв □сс		D 🗆 House 🗆 Major Junio		□ Adult Rec. □ Other	
BODY PART IN			Back		er Trunk 	Abdomen		Sprain 🛛 🗆 St	aceration	sion	
Eye Area 🗆 Throa			al 🗆 Neck	🗆 Upp	er 🗆 Ribs 🗆	Chest		Dislocation LI Se	eparation 🗆 Intern	al Organ Injury	
Arm: □ Left □ Co □ Right □ Ell		•		eft □ ght □				N-SITE CAR			
☐ Shoulder ☐ Ha	and/Fing		Shin		I Thigh □ Groi	n			nly 🗆 Refused C		
					CAUSE OF □ Hit by Puck	INJURY		age group?	player in the correct league and level for the		
INJURY CONDITIONS Name of arena / location: Exhibition/Regular Season Period #2			—	Collision with			☐ Yes ☐ No Was this a sanctioned Hockey Canada activity?				
Exhibition/Regular	Season		Period #2		□ Non-Contact I □ Hit by Stick			☐ Yes ☐ No			
□ Playoffs/Tournament □ Period #3 □ Practice □ Overtime: □ Try-outs □ Dry Land Train				Collision on O			LOCATION Defensive Zone Offensive Zone Neutral Zone				
			ng	□ Fall on Ice □ Checked from	Rehind						
□ Other □ Gradual Onse □ Warm-up □ Other Sport				□ Collision with			□ Behind the □ Parking Lot	ne Net 🔲 3 ft. from Boards 🗆 Spectator Area ot 🔹 Dressing Room 🗆 Bench			
\square Period #1			Other:		□ Fight □ Blindsiding						
WEARING WHEN INJURE Full Face Mask Intra-Oral Mouth G Half Face Shield/V Throat Protector Helmet/No Face S No Helmet/No Face Short Gloves Long Gloves	uard 'isor hield		before? If "Yes" how lo Was a penalty incident? Estimated ab	ATIO r sustai es D N ong ago called a ćes D sence fi	ined this injury No as a result of the No	Accidet (Attach page if nece	NT H	IAPPENED	Physician, Dentist or attended or examine Hockey Canada any respect to any illness consultation, prescri of all dental, hospita static/electronic cop		
										Branch	
(To be completed by a			al)	THIS	ALTH INSURA MUST BE FILLED 0	UT IN FULL OF	R FOR	M PROCESSING		APPROVAL	
(To be completed by a Team Official) Association:			Occupation: Employed Full-time Unemployed Full-time Full-time Full-time Student Full-time Student Constraints Full-time Student Full-time								
Team Name:			Employer (If minor, list parent's employer):								
Team Official (Print):			1. Do you have provincial health coverage? □ Yes □ No 2. Do you have other insurance? □ Yes □ No								
Team Official Position:			(IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.)								
Team Official Position: Signature:			3. Has a claim been submitted? □ Yes □ No (IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATIONS OF BENEFITS.)								
Date:					e Claim Payable To:				-		



HOCKEY CANADA INJURY REPORT

PAGE 2/2



Last name Given name PAYABLE FROM THIS CL DIRECTLY TO THE NAME DIRECTLY TO THE NAME		
Nature of Injury: Date of First Attendance: Claimant will be totally disabled: From: To: Claimant will be totally disabled: From: To: Is the injury permanent and irrecoverable? No 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 of coverage: Signed: Date of coverage: Dentist INNQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO. Iterest Address Iterest Address To: INNQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO. Iterest Address Iterest Address The output for the mame Address		
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FOR DENTIST USE ONLY – FOR ADDITIONAL INFORMATION.		
DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION.		
DENTIST FOR THE ENTIRE TREATMENT.		
I ACKNOWLEGDE THAT THE TOTAL FEE OF \$ IS ACCURATE AND HAS B CHARGED TO ME FOR THE SERVICES RENDERED.	EEIN	
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM T	O MY	
DUPLICATE FORM D INSURING COMPANY/PLAN ADMINISTRATOR.		
SIGNATURE OF (PATIENT/GUARDIAN) OFFICE VERIFICATION		
DATE OF SERVICE PROCEDURE INITIAL TOOTH TOOTH SURFACE DENTIST'S FEE LAB CHARGE TOTAL CHAR		
DAY / MO. / YR. FROCEDORE CODE TOTAL OTHIS OR ACE DENTISTS TEE LAD CHARGE TOTAL CHAR		
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.		
lail completed form to: Hockey Canada Tel: 613-562-5677		
801 King Edward Avenue, Suite N204 Fax: 613-562-5676 Ottawa, Ontario K1N 6N5 www.hockeycanada.ca		