

Date: __

HOCKEY CANADA INJURY REPORT

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See reverse for mailing CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE. DATE OF INJURY: address Mo. Day INJURED PARTICIPANT: ☐ Player ☐ Team Official ☐ Game Official ☐ Spectator Forms must be filled out in full or form will be ___ Birthdate: __/__/ __ Sex: □ M □ F returned. This form must be completed for each case where an injury is Address: ___ sustained by a player. spectator or any other _____ Province: _____ Postal Code: _____ Phone: (____) ____ person at a sanctioned hockey activity Parent / Guardian: CATEGORY DIVISION □ AAA □ A □ BB □ CC □ DD □ House ☐ Initiation ☐ Novice ☐ Atom ☐ Peewee ☐ Minor Junior ☐ Adult Rec. □ AA □ B □ C □ D □ E □ Major Junior □ Senior ☐ Bantam ☐ Midget ☐ Juvenile ☐ Junior □ Other **BODY PART INJURED** NATURE OF CONDITION ☐ Concussion ☐ Laceration ☐ Fracture ☐ Strain ☐ Contusion ☐ Sprain Head Back Trunk ☐ Abdomen ☐ Face ☐ Skull ☐ Lower ☐ Dislocation ☐ Separation ☐ Internal Organ Injury \square Eye Area \square Throat \square Dental ☐ Ribs ☐ Chest ☐ Neck ☐ Upper **Arm**: □ Left □ Collarbone Leg: ☐ Left ☐ Knee **Pelvis ON-SITE CARE** ☐ Right ☐ Elbow ☐ Right ☐ Toe ☐ Hip ☐ On-Site Care Only ☐ Refused Care ☐ Shoulder ☐ Hand/Finger ☐ Groin ☐ Shin ☐ Thigh ☐ Upper arm ☐ Forearm/Wrist ☐ Sent to Hospital by: ☐ Ambulance ☐ Car ☐ Other ☐ Foot Was the injured player in the correct league and level for their **CAUSE OF INJURY INJURY CONDITIONS** age group? ☐ Hit by Puck Name of arena / location: ____ ☐ Yes ☐ No ☐ Collision with Boards Was this a sanctioned Hockey Canada activity? ☐ Non-Contact Injury ☐ Yes ☐ No ☐ Exhibition/Regular Season ☐ Period #2 ☐ Hit by Stick ☐ Collision on Open Ice ☐ Playoffs/Tournament ☐ Period #3 ☐ Collision with Opponent ☐ Practice ☐ Overtime: LOCATION ☐ Fall on Ice ☐ Try-outs ☐ Dry Land Training ☐ Defensive Zone ☐ Offensive Zone ☐ Neutral Zone ☐ Checked from Behind ☐ Other ☐ Gradual Onset \square Behind the Net \square 3 ft. from Boards \square Spectator Area ☐ Collision with Net ☐ Warm-up ☐ Other Sport ☐ Parking Lot ☐ Dressing Room ☐ Bench ☐ Fight ☐ Other: ☐ Other: _ ☐ Period #1 ☐ Blindsiding I hereby authorize any Health Care Facility, WEARING **ADDITIONAL DESCRIBE HOW** Physician, Dentist or other person who has **ACCIDENT HAPPENED** WHEN INJURED INFORMATION attended or examined me/my child, to furnish (Attach page if necessary) Has the player sustained this injury Hockey Canada any and all information with ☐ Full Face Mask respect to any illness or injury, medical history, before? ☐ Yes ☐ No ☐ Intra-Oral Mouth Guard consultation, prescriptions or treatment and copies ☐ Half Face Shield/Visor If "Yes" how long ago _ of all dental, hospital, and medical records. A photo ☐ Throat Protector static/electronic copy of this authorization shall be Was a penalty called as a result of the ☐ Helmet/No Face Shield incident? ☐ Yes ☐ No considered as effective and valid as the original. ☐ No Helmet/No Face Shield Estimated absence from hockey? Signed: ☐ Short Gloves (Parent/Guardian if under 18 years of age) \square 1 week \square 1-3 weeks \square 3+ weeks ☐ Long Gloves Branch TEAM INFORMATION **HEALTH INSURANCE INFORMATION** APPROVAL THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED (To be completed by a Team Official) Occupation: ☐ Employed Full-time ☐ Employed Part-time ☐ Unemployed ☐ Full-Time Student Association: _ Employer (If minor, list parent's employer): _ Team Name:___ 1. Do you have provincial health coverage? ☐ Yes ☐ No Province: Team Official (Print): 2. Do you have other insurance? \square Yes \square No (IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.) Team Official Position: 3. Has a claim been submitted? ☐ Yes ☐ No (IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATIONS OF BENEFITS.) Signature: Make Claim Payable To: ☐ Injured Person ☐ Parent ☐ Team ☐ Other: _



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| PHYSICIAN'S STATI | EMENT | | | | | | |
|--|---|--|---|---------------------------|----------------|---|--|
| Physician: | | A | ddress: | | Tel: (|) | |
| Name of Hospital / Clinic: | | | | — Address: | | | |
| Nature of Injury: | | | | Date of First Attendance: | | | |
| | Claimant will be totally dis | | | | | | |
| | From: | | | To: | | | |
| | Is the injury permanent and irrecoverable? $\ \square$ No | | d irrecoverable? □ No □ Yes | | | | |
| Give the details of injury (degr | ee): | | | | | | |
| Prognosis for recovery: | | | | | | | |
| | | | | | | | |
| | , a. , | | | | | | |
| Was the claimant hospitalized | ? □ No □ Yes (g | ive hospital name | e, address and date a | dmitted): | | | |
| Names and addresses of othe | r physicians or surge | ons, if any, who a | ttended claimant: | | | | |
| | | - 46 - 6 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 | lun avvil a al eta | | | | |
| I certify that the above information is correct and to the best of my knowledge, Signed: Date: | | | | | | | |
| 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. | | | | |
| Patient | | | Dentist | | | I HEREBY ASSIGN MY BENEFITS | |
| | | | | | | PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST | |
| Last name Given name Address | | | | | | AND AUTHORIZE PAYMENT | |
| | | | | | | DIRECTLY TO HIM / HER | |
| | | | | | | | |
| City / Town Province Postal Code | | | | | | | |
| City / Town Province Postal Code | | | PHONE NO | | | SIGNATURE OF SUBSCRIBER | |
| FOR DENTIST USE ONLY – FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES OR SPECIAL CONSIDERATION. | | | 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 | | | | |
| DUPLICATE FORM □ | INSURING COMPAN | Y/PLAN ADMINISTR | ATOR. | | | | |
| | SIGNATURE OF (PATIENT/GUARDIAN) OFFICE VERIFICATION | | | | | | |
| DATE OF SERVICE | T | INITIAL TOOTH | T | | | | |
| DAY / MO. / YR. | PROCEDURE | CODE | TOOTH SURFACE | DENTIST'S FEE | LAB CHARGE | TOTAL CHARGE | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | 1 | | |
| THIS IS AN ACCURATE STATEM | TENT OF SERVICES P | ERFORMED AND | THE TOTAL FEE DUE AI | ND PAYABLE & OE. | TOTAL FEE SUBM | ITTED | |
| NOTE: All benefits subject to insu | rer payor status, provisi | ons of the policy, H | ockey Canada sanctione | ed events. | | | |

Mail completed form to: HOCKEY ALBERTA

100 College Blvd. Box 5005, Room 2606 Red Deer, AB T4N 5H5

Tel : (403) 342-6777 Fax: (403) 346-4277

www.hockey-alberta.ca