



HOCKEY CANADA INJURY REPORT



CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF INJURY.

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.

Mail to: BLOMHA
3455 Fairview Street
Burlington, ON L7N 2R4

INJURED PARTICIPANT: Player Team Official Game Official Spectator INJURY DATE: DD / MM / YY

Name Birthdate DD / MM / YY Sex M F

Address City/Town

Province Postal Code Telephone

Parent/Guardian

DIVISION:

Development 4/5 Novice Minor PeeWee Bantam
 Development 6 Minor Atom PeeWee Minor Midget
 Pre-Novice Atom Minor Bantam Midget

CATEGORY:

House League Rep 'A' Select
 Other _____

BODY PART INJURED: Visit the Hockey Canada website for an optional questionnaire

Head	Back	Trunk	Arm <input type="checkbox"/> Left <input type="checkbox"/> Right	Pelvis	Leg <input type="checkbox"/> Left <input type="checkbox"/> Right
<input type="checkbox"/> Eye Area <input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Ribs	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hip	<input type="checkbox"/> Thigh
<input type="checkbox"/> Skull <input type="checkbox"/> Dental	<input type="checkbox"/> Upper	<input type="checkbox"/> Chest	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Groin	<input type="checkbox"/> Knee
<input type="checkbox"/> Throat	<input type="checkbox"/> Lower	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Elbow	<input type="checkbox"/> Collarbone	<input type="checkbox"/> Foot
					<input type="checkbox"/> Toe
					<input type="checkbox"/> 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 Tryouts Other
 Warm-up Period #1 Period #2 Period #3 Overtime # _____
 Dry Land Training Gradual Onset Other Sport Other _____

Was the injured player in the correct league and level for their age group? Yes No
 Was this a sanctioned Hockey Canada hockey activity? Yes No

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 Checked

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 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 photostatic/electronic copy of this authorization shall be considered as effective and valid as the original.

Sign _____ Date DD / MM / YY
 Parent/Guardian if under 18 years of age

TEAM INFORMATION: (To be completed by a Team Official)

Association _____ Team Name _____ Game No. _____

Team Official (Print) _____ Team Official Position _____

Signature _____ Date _____

HEALTH INSURANCE INFORMATION: THIS MUST BE FILLED OUT IN FULL OR 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 EXPLANATION OF BENEFITS)

Make claim payable to: Injured person Parent Team Other _____

Branch APPROVAL

PHYSICIAN'S STATEMENT

Physician _____ Address _____ Telephone () _____

Name of hospital/clinic _____ Address _____

Nature of injury: _____ Date of first attendance _____ DD / MM / YY

_____ Claimant will be totally disabled:

_____ From DD / MM / YY To DD / MM / YY

Is the injury permanent and irrecoverable? No Yes

Give details of injury (degree): _____

Prognosis for recovery: _____

Did any disease or previous injury contribute to the current injury? No Yes (describe): _____

Was 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 to the best of my knowledge

Signed _____ Date DD / MM / YY

DENTIST'S STATEMENT Limits of coverage: \$1,000 per tooth, \$2,000 per accident • Treatment must be completed within 52 weeks of accident						
P A T I E N T	LAST NAME _____		UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT 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	
	GIVEN NAME _____		D E N T I S T Telephone _____			
	ADDRESS _____ APT. _____					
	CITY _____ PROV. _____ POSTAL CODE _____					
FOR DENTIST'S 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 ACKNOWLEDGE THAT THE TOTAL FEE OF \$ _____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR. _____ SIGNATURE OF (PATIENT/GUARDIAN)			
DPLICATE FORM <input type="checkbox"/>			OFFICE VERIFICATION			
DATE OF SERVICE DD / MM / YY	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:
 Burlington Lions Optimist Minor Hockey Association, 3455 Fairview Street, Burlington, ON L7N 2R4