



# 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: \_\_\_/\_\_\_/\_\_\_ Gender: ☐ M ☐ F  
Mo. Day Yr.

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:                                   |                                        | Leg:                           |                                | Head:                             |                                | Trunk:                           |                                  | Back:                          |                                |
|----------------------------------------|----------------------------------------|--------------------------------|--------------------------------|-----------------------------------|--------------------------------|----------------------------------|----------------------------------|--------------------------------|--------------------------------|
| Left                                   | Right                                  | Left                           | Right                          |                                   |                                |                                  |                                  |                                |                                |
| <input type="checkbox"/> Shoulder      | <input type="checkbox"/> Shoulder      | <input type="checkbox"/> Shin  | <input type="checkbox"/> Shin  | <input type="checkbox"/> Eye Area | <input type="checkbox"/> Face  | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Chest   | <input type="checkbox"/> Neck  | <input type="checkbox"/> Lower |
| <input type="checkbox"/> Upper arm     | <input type="checkbox"/> Upper arm     | <input type="checkbox"/> Knee  | <input type="checkbox"/> Knee  | <input type="checkbox"/> Throat   | <input type="checkbox"/> Skull | <input type="checkbox"/> Ribs    | <input type="checkbox"/> Pelvis: | <input type="checkbox"/> Upper |                                |
| <input type="checkbox"/> Collarbone    | <input type="checkbox"/> Collarbone    | <input type="checkbox"/> Toe   | <input type="checkbox"/> Toe   | <input type="checkbox"/> Dental   |                                | <input type="checkbox"/> Hip     | <input type="checkbox"/> Groin   |                                |                                |
| <input type="checkbox"/> Elbow         | <input type="checkbox"/> Elbow         | <input type="checkbox"/> Thigh | <input type="checkbox"/> Thigh | <b>Other:</b>                     |                                |                                  |                                  |                                |                                |
| <input type="checkbox"/> Hand/Finger   | <input type="checkbox"/> Hand/Finger   | <input type="checkbox"/> Foot  | <input type="checkbox"/> Foot  |                                   |                                |                                  |                                  |                                |                                |
| <input type="checkbox"/> Forearm/Wrist | <input type="checkbox"/> Forearm/Wrist |                                |                                |                                   |                                |                                  |                                  |                                |                                |

## 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  
☐ 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<br>MO. / DAY / 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 \_\_\_\_\_

Mail completed form to: **ONTARIO MINOR HOCKEY ASSOCIATION**  
25 BRODIE DRIVE, UNIT 3  
RICHMOND HILL, ON  
L4B 3K7  
[OMHA.NET](http://OMHA.NET)  
[OMHA@OMHA.NET](mailto:OMHA@OMHA.NET)