# 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.) Sex: M F

Address: _____

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

Parent / Guardian: _____

## DIVISION

Initiation Novice Atom Peewee
Bantam Midget Juvenile Junior

## CATEGORY

AAA A BB CC DD House Minor Junior Adult Rec.
AA B C D E Major Junior Senior Other _____

## BODY PART INJURED

**Head** Face Skull
Eye Area Throat Dental

**Back** Lower
Neck Upper

**Trunk** Abdomen
Ribs Chest

**Arm:** Left Collarbone
Right Elbow
Shoulder Hand/Finger
Upper arm Forearm/Wrist

**Leg:** Left Knee
Right Toe
Shin Thigh
Other Foot

**Pelvis**
Hip
Groin

## 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
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 a 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 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: _____

Branch
APPROVAL

# HOCKEY CANADA INJURY REPORT



## 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, $2,500 per accident
Treatment must be completed within 52 weeks of accident

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 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 INSURING COMPANY/PLAN ADMINISTRATOR.

_____ _____
SIGNATURE OF (PATIENT/GUARDIAN) OFFICE VERIFICATION

| DATE OF SERVICE DAY / MO. / 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

**HOCKEY DEVELOPMENT CENTRE FOR ONTARIO**
**HOCKEY TRAINERS CERTIFICATION PROGRAM**
**INJURY DATA COLLECTION PROGRAM**
# ONLINE REPORTING FORM

**TO BE COMPLETED ONLINE AT:**
**www.hdco.on.ca (Safety Initiatives)**

| ASSOCIATION | ☐ ALLIANCE | ☐ GTHL | ☐ NOHA | ☐ OHA | ☐ OHL | ☐ OMHA | ☐ OWHA | ☐ ODHA | ☐ ODMHA | ☐ HNO |
|---|---|---|---|---|---|---|---|---|---|---|

| LEVEL OF PLAY: | | CLASSIFICATION: | | CATEGORY | POSITION |
|---|---|---|---|---|---|
| ☐ INITIATION | ☐ BANTAM | ☐ AAA | ☐ C | ☐ HOUSE LEAGUE | ☐ FORWARD |
| ☐ MINOR NOVICE | ☐ MINOR MIDGET | ☐ AA | ☐ DD | ☐ SELECT | ☐ DEFENSE |
| ☐ NOVICE | ☐ MIDGET | ☐ A | ☐ D | ☐ REP | ☐ GOALTENDER |
| ☐ MINOR ATOM | ☐ JUVENILE | ☐ BB | ☐ EE | | ☐ OTHER (SPECIFY) |
| ☐ ATOM | ☐ JUNIOR | ☐ B | ☐ E | | |
| ☐ MINOR PEEWEE | ☐ INTERMEDIATE | ☐ CC | ☐ OTHER (SPECIFY) | | |
| ☐ PEEWEE | ☐ SENIOR | | | | |
| ☐ MINOR BANTAM | ☐ OTHER (SPECIFY) | | | | |

| | | | |
|---|---|---|---|
| NAME OF TEAM | | | |
| LOCAL ASSOCIATION | | | |
| NAME OF ARENA | | TOWN/CITY | |

| | | | | | |
|---|---|---|---|---|---|
| PLAYER'S NAME **(Optional)** | | GENDER (Male or Female) | | AGE | |
| ADDRESS **(Optional)** | | TOWN/CITY **(Optional)** | | | |
| | | POSTAL CODE **(Optional)** | | | |

| ACTIVITY | | | CATEGORY | PERIOD OF GAME | |
|---|---|---|---|---|---|
| | ☐ GAME | ☐ PRACTICE | ☐ HOME | ☐ 1ST | ☐ OT |
| | ☐ EXHIBITION | ☐ PLAYOFF | ☐ AWAY | ☐ 2ND | |
| | ☐ TOURNAMENT | ☐ OFF-ICE | | ☐ 3RD | |
| | ☐ OTHER (SPECIFY) | | | | |

| LOCATION OF INJURY ON BODY | | | | |
|---|---|---|---|---|
| | ☐ ANKLE | ☐ FACE | ☐ LOWER ARM | ☐ SPINE |
| | ☐ BACK (LOWER) | ☐ FINGER | ☐ LOWER LEG | ☐ STERNUM |
| | ☐ BACK (UPPER) | ☐ FOOT | ☐ NECK | ☐ THIGH |
| | ☐ DENTAL | ☐ GROIN | ☐ RIBS (FRONT) | ☐ UPPER ARM |
| | ☐ EAR | ☐ HEAD | ☐ RIBS (SIDE) | ☐ WRIST |
| | ☐ EYE | ☐ HIP | ☐ SHOULDER | |
| | ☐ ELBOW | ☐ INTERNAL | ☐ OTHER (SPECIFY) | |

| TYPE OF INJURY | | | |
|---|---|---|---|
| | ☐ BRUISE | ☐ FRACTURE | ☐ STRAIN |
| | ☐ CONCUSSION | ☐ LACERATION | ☐ OTHER ( SPECIFY) |
| | ☐ DISLOCATION | ☐ SPRAIN | |

| SIGNS/SYMPTOMS OF INJURED PLAYER | | | |
|---|---|---|---|
| | ☐ DEFORMITY | ☐ LOSS OF CONSCIOUSNESS | ☐ SHORTNESS OF BREATH |
| | ☐ HEAVY BLEEDING | ☐ LOSS OF FEELING | ☐ OTHER (SPECIFY) |
| | ☐ LIGHT BLEEDING | ☐ PAIN | |

| CAUSE OF INJURY | | | | |
|---|---|---|---|---|
| | ☐ BOARDS | ☐ FAULTY EQUIPMENT | ☐ PUCK | ☐ OTHER (SPECIFY) |
| | ☐ BODY CHECK | ☐ FELL ON ICE | ☐ SKATE | |
| | ☐ CHECK FROM BEHIND | ☐ NET | ☐ STICK | |
| | ☐ COLLISION | ☐ POOR FITTING EQUIPMENT | ☐ TRIP | |

| LOCATION ON ICE WHERE INJURY OCCURRED | | | | |
|---|---|---|---|---|
| | ☐ DEFENSIVE ZONE | ☐ GOAL CREASE | ☐ OTHER (SPECIFY) | |
| | ☐ NEUTRAL ZONE | ☐ PLAYERS' BENCH | HOW LONG WAS PLAYER OUT OF HOCKEY? SPECIFY # OF DAYS | |
| | ☐ OFFENSIVE ZONE | ☐ PENALTY BENCH | | |

| WAS PLAYER TRANSPORTED TO HOSPITAL? | MODE OF TRANSPORTATION | IF PLAYER WAS HOSPITALIZED PROVIDE: | NAME OF HOSPITAL | |
|---|---|---|---|---|
| ☐ YES ☐ NO | ☐ AMBULANCE ☐ PRIVATE VEHICLE ☐ OTHER (SPECIFY) | | CITY/TOWN | |

| TYPE OF MEDICAL CARE | HAS THE PLAYER SUSTAINED THIS INJURY BEFORE? | WAS A PENALTY CALLED AS A RESULT OF THIS INJURY? | STATE PENALTY: |
|---|---|---|---|
| ☐ FAMILY PHYSICIAN | | | |
| ☐ EMERGENCY CLINIC | | | |
| ☐ SPORTS CLINIC | ☐ YES ☐ NO | ☐ YES ☐ NO | WAS THE PENALTY CALLED ON THE:: ☐ OPPOSING PLAYER ☐ INJURED PLAYER |
| ☐ OTHER (SPECIFY) | | | |

| DID THE HOCKEY TRAINERS' CERTIFICATION PROGRAM ASSIST YOU IN YOUR MANAGEMENT OF THE INJURY SITUATION? | | | | ☐ YES ☐ NO | |
|---|---|---|---|---|---|
| TRAINER'S NAME | | TRAINER'S ID # | | LEVEL | ☐ 1 ☐ 2 ☐ 3 |
| DATE INJURY OCCURRED (M/D/Y) | | COMMENTS: | | | |
| DATE REPORT COMPLETED (M/D/Y) | | | | | |