



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.



# CANADIAN HOCKEY INJURY REPORT

CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF INJURY. INJURY DATE: \_\_\_/\_\_\_/\_\_\_

INJURED PARTICIPANT:  Player  Team Official  Game Official  Spectator

Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Sex: (M) (F)

Address: \_\_\_\_\_ City/ Town \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

### DIVISION:

- Initiation  Novice  Atom  PeeWee
- Bantam  Midget  Juvenile

### CATEGORY:

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

### BODY PART INJURED: \* visit the CHA web-site for an optional questionnaire \*

- |   |                                |                                  |                                   |  |                                |                                |  |
|---|--------------------------------|----------------------------------|-----------------------------------|--|--------------------------------|--------------------------------|--|
| <b>Head</b>   | <b>Back</b>                    | <b>Trunk</b>                     | <b>Arm</b>                        | <input type="checkbox"/> Left <input type="checkbox"/> Right | <b>Pelvis</b>                  | <b>Leg</b>                     | <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"/> Hand/Finger                         | <input type="checkbox"/> Hip   | <input type="checkbox"/> Thigh | <input type="checkbox"/> Foot                                |
| <input type="checkbox"/> Throat <input type="checkbox"/> Dental | <input type="checkbox"/> Upper | <input type="checkbox"/> Chest   | <input type="checkbox"/> Upperarm | <input type="checkbox"/> Forearm/Wrist                       | <input type="checkbox"/> Groin | <input type="checkbox"/> Knee  | <input type="checkbox"/> Toe                                 |
| <input type="checkbox"/> Skull                                  | <input type="checkbox"/> Lower | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Elbow    | <input type="checkbox"/> Collarbone                          | <input type="checkbox"/> Shin  | <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  Try-outs  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 CHA 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

### 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 the CHA 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.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Guardian if under 18 years of age)

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

Association: \_\_\_\_\_ Team Name : \_\_\_\_\_

Team Official (Print): \_\_\_\_\_ Team Official Position: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### HEALTH INSURANCE INFORMATION:

- 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: \_\_\_\_\_ 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 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: \_\_\_\_\_

**DENTIST'S STATEMENT**Limits of coverage: \$1,000 per tooth, \$2,000 per accident  
Treatment must be completed within 52 weeks of accident

	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
P A T I E N T	D E N T I S T	SIGNATURE OF SUBSCRIBER
LAST NAME GIVEN NAME ADDRESS APT. CITY PROV. POSTAL CODE	PHONE NO.	

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.

DUPLICATE FORM 

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 &amp; OE.

NOTE: All benefits subject to insurer payor status, provisions of the policy, CHA sanctioned events.

**TOTAL FEE  
SUBMITTED**

**Mail completed form to:  
British Columbia Amateur Hockey Association  
6671 Oldfield Rd, Saanichton BC V8M 2A1  
P: 250-652-2978 F: 250-652-4536**