(?)-								
$\mathcal{D} =$	HOCKEY	CAN	NADA	INJU	RY RE	PORT	CANADA	
<b>YOMHA</b>	CLAIMS MUST BE PR	ESENT	ED WITHIN	90 DAYS OF	INJURY. INJ	URY DATE:	//	
<i></i>	INJURED PARTICIP	ANT:	□ Player	🗆 Team Of	ficial 🗆 Ga	me Official	□ Spectator	
See reverse for mailing address	Name:		•				-	
Forms must be filled out in full or form will be returned. This form								
must be completed for each case	Address:				-			
where an injury is sustained by a player, spectator or any other person	Province:		_Postal Code:		Pho	ne: ()		
at a sanctioned hockey activity.	Parent/Guardian:							
DIVISION:		CAT	EGORY:					
□ Initiation □ Novice	□ Atom □ PeeWee							
□ Bantam □ Midget	□ Juvenile	$\square$ D $\square$ Se				_ Major Junioi	Minor Junior	
BODY PART INJURED	: * visit the Hockey Can							
	<u>ack Trunk</u>		$\Box$ Left $\Box$ R		Pelvis	Leg 🗌 L	eft 🗌 Right	
$\Box$ Eye Area $\Box$ Face $\Box$		□ Shou		and/Finger		= v	🗆 Foot	
$\Box$ Throat $\Box$ Dental $\Box$				orearm/Wrist	🗆 Groin			
Skull	$\frac{\text{Lower}  \Box \text{ Abdomen}}{\text{ON}}$	□ Elbo		ollarbone	$\mathbf{RE} \square \mathbf{On}$		□ Other □ Refused Care	
$\Box$ Concussion $\Box$ Lacera		Sprain	□ Strain			Ambulance		
$\Box$ Contusion $\Box$ Disloca					1,			
INJURY CONDITIONS					•			
□ <u>Exhibition/Regular Se</u> □ Warm-up		ayoffs/1 Period #	burnament	□ <u>Pract</u> eriod #3		<u>Try-outs</u> #	□ <u>Other</u>	
1	$\Box$ Gradual Onset $\Box$			ther:		π		
Was the injured player in					🗆 No			
Was this a sanctioned Ho	ockey Canada hockey ac	tivity?						
CAUSE OF INJURY:	ion with Doordo 🗆 No	Canta	of Terliner		N: zone □ Off		🗆 Nautual Zana	
$\Box \text{ Hit by Puck} \Box \text{ Collis}$ $\Box \text{ Hit by Stick} \Box \text{ Collis}$		n-Contac	ith Opponent			from boards	<ul> <li>Neutral Zone</li> <li>Spectator Area</li> </ul>	
	1	llision w	11	$\Box$ Parking L		ssing Room		
$\Box$ Fight $\Box$ Blinds				□ Other:		6		
WEARING WHEN INJU		_		AL INFORM				
□ Full Face Mask □ Intra-Oral Mouth Guard □ Half Face Shield/Visor □ Throat Protector			Has the player sustained this injury before? $\Box$ Yes $\Box$ No					
		Shield	If "Yes" how long ago Was a penalty called as result of the incident?  Yes  No					
<ul> <li>☐ Helmet/No Face Shield</li> <li>☐ No Helmet/No Face Shield</li> <li>☐ Short Gloves</li> <li>☐ Long Gloves</li> </ul>			Estimated Absence from hockey? $\Box$ 1 week $\Box$ 1-3 weeks $\Box$ 3+ weeks					
DESCRIBE HOW ACCI (Attach page if necessary)		or examin illness or hospital, considere	ned me/my child injury, medical , and medical re ed as effective ar	d, to furnish Hoc history, consulta ecords. A photo nd valid as the or	key Canada any ation, prescriptio ostatic/electron riginal.	and all informati ns or treatment an ic copy of this a	son who has attended on with respect to any id copies of all dental, uthorization shall be	
		Signed: _ (Parent/G	Juardian if under	18 years of age)		Date:		
TEAM INFORMATION Association:	: (To be completed by a	Team Of	fficial)					
Team Official (Print):								
Signature:								
HEALTH INSURANCE			Date.	·				
THIS MUST BE FIL Occupation: □ Employed Employer (If minor, list pa 1. Do you have provincial 2. Do you have other insura 3. Has a claim been submi Make Claim Payable To:	LED OUT IN FULD I Full-time Employer arent's employer): health coverage? Ye nce? Yes No (IF "Yi tted? Yes No (IF "Yi	d Part-tin es 🗌 No ES", PLEAS ES", PLEA	me Unem o Province: SE SUBMIT CLAIN SE FORWARD P	nployed	Full-Time Stu ARY HEALTH IN ER EXPLANATIO	dent SURER.) N OF BENEFITS)	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:							
					·					
Is the injury perman Give details of injur	ent and irrecoverablery (degree) :	le? □ N	o 🗌 Yes							
Prognosis for recover										
Did any disease or p	previous injury contr	ibute to t	he current in	njury? 🗌 No 🔲 Y	es (describe): _					
Was claimant hospi	talized? 🗌 No 🗌	] Yes (giv	ve hospital na	ame, address and dat						
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:										
		r: ., c	¢1.000		•••					
DENTIST'S STATEMENT Limits of coverage: \$1,000 per tooth, \$2,000 per accident Treatment must be completed within 52 weeks of accident										
P LAST NAME GIVEN NAME D A T I ADDRESS APT. E I			E 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			
N S S T CITY PROV. POSTAL CODE T		S T	PHONE NO.			SIGNATURE OF SUBSCRIBER				
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 VE	ERIFICATION						
DATE OF SERVICE			L TOOTH	ТООТН	DENTIST'	'S	LAB	TOTAL		
DAY / MO. / YR.	/ YR. PROCEDURE		ODE	SURFACE	FEE		CHARGE	CHARGE		
				RFORMED AND THE TOTAL FEE DUE AND PAYABLE & OE.			TOTAL FEE SUBMITTED			

Mail completed form to:	
Ontario Minor Hockey Association	
25 Brodie Drive, Unit #3, Richmond Hill, ON L4B 3K	7
Phone: 905-780-6642 Fax: 905-780-0344	