ACCIDENT INCIDENT REPORT FORM

PLEASE COMPLETE THIS FORM WHENEVER AN ACCIDENT OCCURS WHICH REQUIRES SOME FORM OF MEDICAL ATTENTION. INCLUDES ATHLETES, OFFICIALS, COACHES AND VOLUNTEERS, ETC. THIS FORM MUST ACCOMPANY ANY MEDICAL OR DENTAL CLAIM.

The information which you provide on this form allows us to establish causes of and types of injuries related to soccer as part of a long term research effort to improve preventative measures.

Please indicate activity in which injured person was participating:

- ❑ Practice
- ❑ Game
- ❑ Sanctioned Tournament
- ❑ Non-Sanctioned Tournament

Please state whether the activity was: ❑ Indoor ❑ Outdoor

Name of Injured Person: _____
Surname Given Name

Address: _____

City: _____ Province: _____ Postal Code _____

Phone # ( )_____ Age _____ Date of Birth _____ Male ___ Female ___

Date of Accident _____ Location of Accident _____

Club Name _____ Address_____

Team Name _____ League Name _____

Age Group: Under 18 _____ Over 18 _____

PLEASE CHECK APPROPRIATE BOX TO DESCRIBE ACCIDENT:

- ❑ Collision with another
- ❑ Collision with _____
- ❑ Hit from behind
- ❑ Trip (no contact)
- ❑ Hit with _____
- ❑ Jumping over player
- ❑ Surface problem

Other: _____

Was a penalty called: ❑ YES ❑ NO
Against you: ❑ YES ❑ NO
What Infraction:

- ❑ Fighting
- ❑ Roughing
- ❑ Tripping
- ❑ Dangerous play
- ❑ Tackling
- ❑ Other _____

PLEASE CHECK EQUIPMENT INJURED PERSON WAS WEARING:

- ❑ Shin pads
- ❑ Knee Brace
- ❑ Elbow pads
- ❑ Keeper gloves
- ❑ Mouth guard

Other: _____

Footwear:

- ❑ Boots long studs
- ❑ Boots short studs
- ❑ Running shoes
- ❑ Padded keeper shorts
- ❑ Groin protection

Other: _____

PLEASE INDICATE TYPE OF INJURY: (this accident)

- ❑ Dental
- ❑ Concussion
- ❑ Fracture
- ❑ Bruise
- ❑ Muscle pull
- ❑ Sprain (joints)
- ❑ Internal Injury
- ❑ Skin (wound/puncture)
- ❑ Torn ligament
- ❑ Dislocation
- ❑ Laceration
- ❑ Torn cartilage

PLEASE INDICATE THE BODY PARTS INJURED: (this accident)

- ❑ Knee
- ❑ Hip
- ❑ Teeth
- ❑ Hand
- ❑ Ankle
- ❑ Back
- ❑ Face
- ❑ Fingers
- ❑ Foot
- ❑ Spine
- ❑ Neck
- ❑ Upper arm
- ❑ Chest
- ❑ Chin
- ❑ Wrist
- ❑ Thigh
- ❑ Eye
- ❑ Achilles Tendon
- ❑ Nose
- ❑ Shoulder
- ❑ Elbow
- ❑ Head
- ❑ Calf
- ❑ Collar bone
- ❑ Ear
- ❑ Hamstring
- ❑ Thumb
- ❑ Mid Section
- ❑ Other _____

OUTDOOR –(this accident):

Position played:
❑ Striker ❑ Winger ❑ Midfielder ❑ Defender ❑ Keeper

Playing surface:
❑ Grass ❑ Clay ❑ Wet ❑ Dry ❑ Artificial Turf
❑ Other _____

Hazards of playing surface:
❑ Sprikler heads ❑ Ruts ❑ Holes ❑ Cans/Litter ❑ Glass/Bottles
❑ Rocks

Goal posts: ❑ Wood ❑ Metal ❑ Square ❑ Round

Other Conditions:
Games played: ❑ Morning ❑ Afternoon ❑ Evening
Weather conditions: ❑ Sunny ❑ Cloudy ❑ Rain
❑ Other _____

Temperature Celsius:
❑ Below 0 ❑ 0-10 ❑ 10-20 ❑ 20-25 ❑ 26-33 ❑ plus 33

INDOOR –(this accident):

Playing surface:
❑ Wood ❑ Rubberized ❑ Concrete ❑ Artificial Turf
❑ Other _____

Position played:
❑ Striker ❑ Winger ❑ Midfielder ❑ Defender ❑ Keeper

Boards Padded: ❑ Yes ❑ No

Type of facility:
❑ School ❑ Arena ❑ Community Centre ❑ Other _____

HOW LONG HAS INDIVIDUAL BEEN ACTIVE IN THE SPORT:

As a player _____ years As a coach _____ years As a referee _____ years

WAS INJURED PERSON TREATED ON SITE OR REFERRED FOR PROFESSIONAL MEDICAL/DENTAL TREATMENT?

On Site: ❑ Yes ❑ No

If "yes", treated by whom? _____
Name

_____
Position

Professional medical/dental treatment? ❑ Yes ❑ No

If "yes" Name of Witness: _____
Full Address: _____
_____

Phone Number: ( ) _____

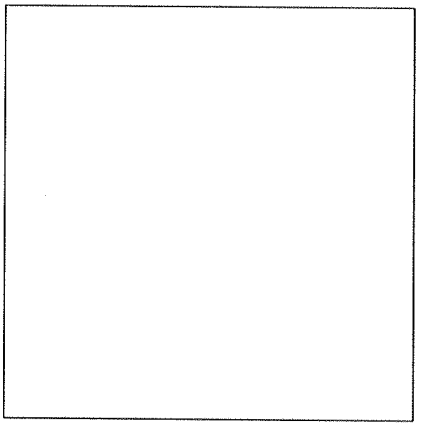
_____ _____
Submitted by (Signature) **Address**

_____ _____
Position **Date**

NOTE: IF MAJOR ACCIDENT, REQUIRE FULL WITNESS REPORTS AS WELL AS ALL OTHER REPORTS TO BE FORWARDED WITHIN TWENTY-FOUR (24) HOURS.

Place an "X" at area of injury
(Draw in circles if necessary)

Place an "O" at your net



SPORT ACCIDENT CLAIM FORM

Claim must be submitted with 90 days of accident
To Be Completed By Player or Parent

Full Name of Insured Player _____ Date of Birth _____

Address _____

Sports Association, League or Team Name _____

POLICY NUMBER _____ Accident date _____ Time _____ AM/PM

Location of Accident _____

How Did Accident Occur? _____

Names of Witnesses _____

Describe Nature of Injury _____

Name of Doctor _____ Bus. Phone # ( ) _____

Address of Doctor _____

Give Dates of All Medical Treatments _____

If Hospitalized, Give Name of Hospital _____

Player or Parent Signature _____ Date _____ Phone _____

IMPORTANT: ALL BILLS FOR WHICH COVERAGE EXISTS UNDER THE POLICY MUST BE SUBMITTED
IN THE EVENT OF A DEATH CLAIM, A CERTIFIED COPY OF DEATH CERTIFICATE MUST BE SUBMITTED

MEDICAL REPORT AUTHORIZATION

In connection with injuries sustained by _____ *(Name of Player)* as a result of an accident occurring on _____ 20____ at or near _____ *(Location).*
This is your authority to provide the insurance company with

1) A report including Diagnosis, History of Treatment and Prognosis and
2) To allow an inspection of all hospital records related to injuries received in the accident.

Player or Parent Signature _____ Date _____

****** Have the following section completed by attending physician MANDATORY**

1) Extent of Injury _____
2) Description of Treatment _____
3) Future Treatment (If any) _____

Physician's Signature _____ Date _____

IF THERE IS A CHARGE FOR COMPLETING THIS FORM, IT IS THE RESPONSIBILITY OF THE PATIENT

PLEASE REMIT TO:

CLAIM FOR DENTAL EXPENSE BENEFITS

DENTIST		Patient's Last Name Given Names
	Name _____	_____
	Address _____	Address
	City & Province _____	_____
	Postal Code _____	City Province
	Telephone Number _____	_____
	Social Insurance Number _____	Postal Code
		_____

Date of Service	Tooth Code	Procedure Code	Tooth Surfaces	Lab Charges	Dentist Fee	Total Charge
				TOTAL FEE: $		

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND FEES CHARGED

_____ _____

Dentist's Signature **Date**

FOR DENTIST USE ONLY. FOR ADDITIONAL INFORMATION RE: DIAGNOSIS PROCEDURES, OR COMPLICATIONS, AND SPECIAL CONSIDERATIONS.

_____

_____

_____

_____

_____

_____

I understand that the fees listed in the claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.

_____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN)

I hereby assign my benefits payable from this claim to the above named dentist and authorize payment directly to him.

_____

SIGNATURE OF SUBSCRIBER

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

DENTIST

Is any of the treatment for Orthodontic purposes?

❑ Yes ❑ No

Was the treatment the result of injury?

❑ Yes ❑ No

I hereby certify that the services listed have been

Performed ❑ Planned ❑

If future treatment is planned please indicate estimate date and cost in the additional information section.

_____

_____

_____

_____

_____

PARENT OR GUARDIAN

Were these teeth whole or sound at time of accident?

❑ Yes ❑ No

Were these permanent teeth?

❑ Yes ❑ No

Are any dental benefits or services provided under any other insurance or dental plan?

❑ Yes ❑ No

Name of Insuring Agent:

_____

Policy Number:

_____

Describe dental injury sustained: ____

_____

_____

_____

_____

OTHER INSURANCE DECLARATION

The Insurance Policy as purchased by your sports organization provides for coverage in excess of any private or government medical / dental plan.

If you incur medical or dental expenses as the result of a sports injury, you are required to submit those expenses to your own private medical/dental plan first.

If in the event your personal medical/dental plan does not provide full reimbursement, you are then eligible to submit the amounts of expenses not covered, to your sports association for processing.

Please clarify your situation by checking one of the following:

_____ Yes, I have private coverage and will be submitting my claim directly to my private insurers.

_____ Yes, I have private coverage, but I do not believe that they will provide full reimbursement and would ask that you keep my claim open until we receive notification from the private insurers.

_____ No, I do not maintain any private medical/dental coverage. The expenses I am submitting are not covered by any other plan.

If you are a minor then your parents or legal guardian must complete this form on your behalf.

Name – print _____

Signature _____

Date (mm/dd/yyyy) _____

If the claim is being submitted for a minor, please indicate the name.

Name – print _____

THIS FORM IS TO BE SUBMITTED WITH EVERY SPORTS ACCIDENT CLAIM FORM, DULY COMPLETED AND SIGNED.