ACCIDENT INCIDENT REPORT FORM
LACROSSE

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

SEND IMMEDIATELY TO:

ONTARIO LACROSSE ASSOCIATION
3 Concord Gate, Unit 306
Toronto, ON M3C 3N7

Phone: (416) 426-7066 Fax: (416) 426-7382

The information which you provide on this form allows us to establish causes of and types of injuries related to lacrosse 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
- ❑ Dangerous play
- ❑ Roughing
- ❑ Tackling
- ❑ Tripping
- ❑ Other ______________

PLEASE CHECK EQUIPMENT INJURED PERSON WAS WEARING:

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

Other: ______________

Footwear:

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

Other: ______________

PLEASE INDICATE TYPE OF INJURY: (this accident)

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

PLEASE INDICATE THE BODY PARTS INJURED: (this accident)

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

❑ 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

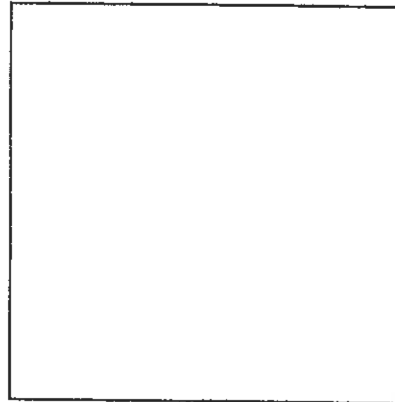
____
Position

____
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	
	Name
	Address
	City & Province
	Postal Code
	Telephone Number
	Social Insurance Number

Patient's Last Name Given Names

Address

City Province

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.

<u>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.</u>

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.