

<u>For Official Sports Use Only</u>	
Individual Membership Status _____	_____
Application Verified _____	Processed _____

SPORTS ACCIDENT CLAIMS

To Be Completed By Player or Parent:

Full Name of Insured Player: _____ Date of Birth _____

Address: _____

Club Name _____ Team Name _____ League Name _____

Policy Number: _____ Accident Date _____ Time _____ a.m./p.m.

Location of Accident: _____

How Did Accident Occur? _____

Name(s) of Witnesses _____

Describe Nature of Injury _____

Name of Doctor _____ Business Telephone: _____

Address of Doctor _____

Give Dates of All Medical Treatments _____

If Hospitalized, Give Name of Hospital _____

Player or Parent's Signature _____ Date _____ Phone: (____) _____ E-Mail _____

**IMPORTANT: All bills for which coverage exists under the policy must be submitted
In the event of a death claim, a certified copy of the death certificated must be submitted**

<u>Medical Report Authorization</u>	
In Connection With Injuries Sustained By _____ (Name of Player) As a Result of An Accident Occurring on _____ 20 _____. At or Near _____	
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/Parent's Signature _____	Date _____

The Following Section Must Be Completed By Attending Physician:

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

<p>Please Remit To</p>	<p>The Ontario Soccer Association Attention: Member Services 7601 Martin Grove Road Vaughan, Ontario - L4L 9E4</p>	<p>Phone Number (905) 264-9390 ext. 228</p>
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SOCCER ACCIDENT REPORT FORM

Please complete the form whenever a soccer 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

SEND IMMEDIATELY TO:

THE ONTARIO SOCCER ASSOCIATION

Attention: Member Services

7601 Martin Grove Road,

Vaughan, Ontario

L4L 9E4

Phone: (905) 264-9390 ext. 228

Fax: (905) 264-9445

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

PLEASE CHECK ACTIVITY IN WHICH INJURED PERSON WAS PARTICIPATING:

OUTDOOR

PRACTICE

League

Tournament

INDOOR

GAME

Cup

Exhibition Game

Name of Injured Person _____

Surname

First

Address: _____

Apt., Street Number, Post Office Box

Street Name

City: _____ Province: _____ Postal Code: _____

Daytime Telephone: (____) _____ Evening Telephone: (____) _____ E-Mail _____

Date of Birth: _____ Team/Age Classification
 Senior Team Male
 Youth Team Female

Date of Accident: _____

Location of Accident: _____

Club Name: _____ Team Name: _____

Club Address: _____ League Name: _____

PLEASE CHECK APPROPRIATE SPACE TO DESCRIBE ACCIDENT:

- | | |
|--|--|
| <input type="checkbox"/> Collision with another player | <input type="checkbox"/> Hit by player |
| <input type="checkbox"/> Collision with goalie | <input type="checkbox"/> Hit with ball |
| <input type="checkbox"/> Collision with net | <input type="checkbox"/> Collision with boards |
| <input type="checkbox"/> Hit from behind | <input type="checkbox"/> Jumping over player |
| <input type="checkbox"/> Trip (No contact) | <input type="checkbox"/> Surface Problem |

Foul Called? Yes No

Against Whom? You Your Opponent

What Infraction Fighting Dangerous Play Tripping Pushing Charging Kicking

PLEASE CHECK EQUIPMENT INJURED PERSON WAS WEARING

General Equipment:			Footwear:
<input type="checkbox"/> Shin Pads	<input type="checkbox"/> Elbow Pads	<input type="checkbox"/> Groin Protection	<input type="checkbox"/> Soccer Boots long studs
<input type="checkbox"/> Knee Brace	<input type="checkbox"/> Keeper Gloves	<input type="checkbox"/> Padded Keeper Shorts	<input type="checkbox"/> Soccer Boots short studs
<input type="checkbox"/> Elbow Pads	<input type="checkbox"/> Mouth Guard		<input type="checkbox"/> Running Shoes/Indoor Shoes

Type of Injury (This Accident)

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Dental | <input type="checkbox"/> Muscle Pull | <input type="checkbox"/> Torn Ligament |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Sprain (Joints) | <input type="checkbox"/> Dislocation |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Internal Injury | <input type="checkbox"/> Laceration |
| <input type="checkbox"/> Bruise | <input type="checkbox"/> Skin (wound/puncture) | <input type="checkbox"/> Torn Cartilage |

Body Parts Injured: (This Accident)

- | | | | |
|---|------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Knee | <input type="checkbox"/> Hip | <input type="checkbox"/> Teeth | <input type="checkbox"/> Hand |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Back | <input type="checkbox"/> Face | <input type="checkbox"/> Fingers |
| <input type="checkbox"/> Foot | <input type="checkbox"/> Spine | <input type="checkbox"/> Neck | <input type="checkbox"/> Thumb |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Chin | <input type="checkbox"/> Wrist | <input type="checkbox"/> Achilles Tendon |
| <input type="checkbox"/> Thigh | <input type="checkbox"/> Eye | <input type="checkbox"/> Nose | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Head | <input type="checkbox"/> Calf | <input type="checkbox"/> Collar Bone |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Hamstring | <input type="checkbox"/> Mid Section | <input type="checkbox"/> Upper Arm |
| <input type="checkbox"/> Other (Please Specify) | | | |

SOCCER ACTIVITY: (This Accident)

<input type="checkbox"/> Outdoor Soccer		<input type="checkbox"/> Indoor Soccer	
Position Played			
<input type="checkbox"/> Striker <input type="checkbox"/> Midfielder	<input type="checkbox"/> Defender <input type="checkbox"/> Keeper	<input type="checkbox"/> Striker <input type="checkbox"/> Defender	<input type="checkbox"/> Keeper
Playing Surface			
<input type="checkbox"/> Grass <input type="checkbox"/> Clay <input type="checkbox"/> Other (Please specify)	<input type="checkbox"/> Artificial Turf <input type="checkbox"/> Field Turf	<input type="checkbox"/> Wood <input type="checkbox"/> Rubberized <input type="checkbox"/> Other (Please specify)	<input type="checkbox"/> Concrete <input type="checkbox"/> Artificial Turf
Goal Posts			
<input type="checkbox"/> Wood <input type="checkbox"/> Metal	<input type="checkbox"/> Square <input type="checkbox"/> Round	<input type="checkbox"/> Wood <input type="checkbox"/> Metal	<input type="checkbox"/> Square <input type="checkbox"/> Round
Hazards of Playing Surface			
<input type="checkbox"/> Sprinkler Heads <input type="checkbox"/> Ruts <input type="checkbox"/> Holes	<input type="checkbox"/> Cans/Litter <input type="checkbox"/> Glass Bottles <input type="checkbox"/> Rocks	<input type="checkbox"/> Surface (Please specify) _____ <input type="checkbox"/> Boards <input type="checkbox"/> Other (Please Specify) _____	

If Accident Occurred During Outdoor Soccer Please Complete the following section

Game Played	<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening
Weather	<input type="checkbox"/> Sunny	<input type="checkbox"/> Cloudy	<input type="checkbox"/> Rain
Temperature Celsius	<input type="checkbox"/> Below 0	<input type="checkbox"/> 0-10	<input type="checkbox"/> 10-20
	<input type="checkbox"/> 20-25	<input type="checkbox"/> 26-33	<input type="checkbox"/> Plus 33

If Accident Occurred During Indoor Soccer Please Complete the Following Section

Type of Facility:

<input type="checkbox"/> School	<input type="checkbox"/> Arena	<input type="checkbox"/> Community Centre	<input type="checkbox"/> Indoor Facility
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Was injured person treated on site or referred for Professional Medical/Dental Treatment?

Treated On Site: Yes No

If "yes", treated by whom?

Name: _____

Position: _____

Referred for Professional medical/dental treatment: Yes No

If "yes", Name of hospital, clinic, or office: _____

Name of person treating injury: _____

Full Address: _____

Phone Number: _____

This Section MUST Be Completed by a Team Coach or Club Official

Submitted by: (Coach/Club Official) _____

Address _____

Position _____

Date _____

NOTE: If major accident, require full witness reports as well as all other reports to be forwarded within twenty-four hours.

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

Place an "O" at your net



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 and please check 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.

Date: _____

Name: _____

Signature: _____

**This form is to be submitted with every sports accident claim form ,
duly completed and signed**
