



Risk Management & Safety Incident/Accident Report



Date of Accident _____ Location/Arena _____ Region _____

Name _____ Association _____

Address _____ City _____

Postal Code _____ Telephone: _____

This Report is to do with:

- ' Dangerous Facility
 - ' Dangerous Situation
 - ' Equipment Failure
 - ' Injury
- (Please submit any support items i.e: failed piece of equipment, diagram or photo of danger area, etc....)

If you checked "Injury", please complete the following:

Type of Injury:

- ' Bruise
- ' Cut
- ' Pull
- ' Sprain/Strain
- ' Twist
- ' Concussion
- ' Fracture
- ' Separation
- ' Tear
- ' Other (specify) _____

Area Injured:

- ' Abdomen
- ' Collar Bone
- ' Foot
- ' Leg
- ' Tailbone
- ' Ankle
- ' Elbow
- ' Hand
- ' Mouth
- ' Teeth
- ' Arm
- ' Eye
- ' Head
- ' Neck
- ' Toe(s)
- ' Back
- ' Face
- ' Hip
- ' Pelvic Area
- ' Wrist
- ' Chest
- ' Finger(s)
- ' Knee
- ' Shoulder
- ' Other _____

Party injured during: (i.e. game) _____

Party was a: (i.e. player or coach) _____

Did the injured party receive treatment? _____

Treatment given by: (i.e. trainer) _____

If so, where and when did it start? _____

Has treatment been completed? _____

If treated at hospital, party transported by: ' Ambulance ' Personal/Private Vehicle

Has injured party filed an Insurance Claim?: ' Yes ' No

Please use the space provided on the reverse of this form to give details of the injury, situation and/or dangerous facility that this report deals with. Please provide photocopies of any other reports that you feel may be pertinent including photo or diagrams of danger area, First Aid reports or medical documents.

Completed by: ' Association Rep. ' Bench Staff _____
 ' Parent ' Self (Please Print Name) (Signature) (Date)
 ' Other

REVERSE SIDE OF THIS FORM MUST ALSO BE COMPLETED

Injury Report:

Please describe events pertaining to how the party was injured: _____

Dangerous Situation Report:

Please describe the situation that has concerned you as "dangerous": _____

Equipment Failure Report:

Equipment item of Concern: _____ Make/Model/#(s): _____

Please describe how this equipment failed: (If it is a "Stick through Mask" we need Helmet and Mask Model #s): _____

Is the piece of equipment enclosed? ' Yes ' No Did injury occur from failure? ' Yes ' No

Dangerous Facility Report:

Name of Facility _____ Phone: _____

Address: _____ Manager: _____

Please describe your concern for danger with this facility? _____

Was this danger reported to: ' Facility Personnel ' Local Association ' Parks & Rec. Dept.

Thank you for taking the time to complete this very important document. Please return completed form within 2 business days to: Ontario Ringette Association, 1185 Eglinton Avenue East, Suite 705, North York, Ontario M3C 3C6 or Fax: 416-426-7359

By Furnishing This Blank the Company Makes No Admission of Liability or Waiver of Its Rights. To Be Completed and Returned Within Fifteen Days.



B.F. LORENZETTI & ASSOC. INC.
 Courtiers d'assurances internationaux / International Insurance Brokers



THIS DOCUMENT MUST BE SENT TO :
 Ontario Ringette Association
 #705 – 1185 Eglinton Ave East,
 North York, ON M3C 3C6

Tél: (416) 426-7204
 Fax: (416) 426-7359

ACCIDENT CLAIM REPORT

GROUP POLICY HOLDER Ringette Canada		POLICY NUMBER SRG 9027681	CERTIFICATE NO.
INSURED'S FULL NAME	STREET ADDRESS	CITY	PROVINCE
DATE OF BIRTH	HEIGHT AND WEIGHT	MARITAL STATUS	TELEPHONE
OCCUPATION PRIOR TO DISABLEMENT	DUTIES	MONTHLY EARNINGS	WEEKLY EARNINGS

1	Give Full description of injury or disease from which you are now suffering. If an injury, tell when, where and how it happened.	SICKNESS <input type="checkbox"/>
		INJURY <input type="checkbox"/>
2 A	Have you ever had this, or a similar condition, in the past?	YES <input type="checkbox"/> Condition(s): _____
B	If yes, state the nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals and clinics	NO <input type="checkbox"/> Dates: _____
3 A	Give exact date when illness began, or injury occurred.	A Date: _____
B	When did you first consult a physician for this condition?	B Date: _____
C	When did you become totally disabled (unable to work)?	C Date: _____
D	When were you able to again perform part of your occupational duties?	D Date: _____
E	When were you able to again perform all your occupational duties?	E Date: _____
F	If still totally disabled, when do you expect your disability to terminate?	F Date: _____

4	Hospitals (Give complete names, addresses and dates of confinement.)	NAMES	ADDRESSES	FROM	TO
5 A	Give names, addresses and telephone numbers of all attending physicians.	NAMES	ADDRESSES	TELEPHONE	
B	Give name, addresses and telephone numbers of usual family physician.				
6	What other accident, sickness or disability insurance do you carry and what organizations or companies have paid you indemnity for sickness or injury?	NAMES	ADDRESSES	BENEFITS	
7	What other medical or surgical treatment has been received during the past 5 years? (Give dates, nature of illness or injury and names and addresses of all treating doctors, hospitals and clinics).				
8	Names and addresses of Employers and length of employment with each?	NAMES	ADDRESSES	FROM	TO

I hereby authorize any hospital, physician or other person who has attended me, or any employer, to furnish American Home Assurance Company or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

Approved by: _____ Dated _____

_____ M.D. SIGN YOUR FULL NAME _____

ATTENDING PHYSICIAN

PHYSICIAN'S STATEMENT ON OTHER SIDE



THIS DOCUMENT MUST BE SENT TO :

Ontario Ringette Association
 #705 – 1185 Eglinton Ave East,
 North York, ON M3C 3C6

Tél: (416) 426-7204
 Fax: (416) 426-7359

ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM

ACCIDENT

PATIENT'S NAME AND ADDRESS	AGE
1 A Diagnosis and Concurrent Conditions (If fracture or dislocation, describe nature and location)	
B Is condition due to injury or sickness arising out of patient's employment? If "Yes" explain	Yes <input type="checkbox"/> No <input type="checkbox"/>
2 A When did symptoms first appear or accident happen? B When did patient first consult you for this condition? C Has patient ever had same Or similar condition? If "Yes" state when and describe	Date _____ Year: _____ Date _____ Year: _____ Yes <input type="checkbox"/> No <input type="checkbox"/>
3 A Nature of surgical or obstetrical procedure, If any (describe fully) B Charge to patient for this procedure including post-operative care C If performed in hospital, give name of hospital	Date performed _____ Year: _____ \$ _____ _____ Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/>
4 Give dates of other medical (non-surgical) treatment, if any	Office _____ Home _____ Hospital _____ Nursing Home _____
5 What other services, if any, did you provide patient? (Itemize, giving dates and fees)	
6 Where registered private duty nurse (R.N.) Services necessary?	
7 Is patient still under your care for this condition? If "No" give date your services terminated	Yes <input type="checkbox"/> No <input type="checkbox"/> Date _____ Year: _____
8 A How long was or will patient be continuously totally disabled? (Unable to work?) B How long was or will patient be partially disabled? C Was house confinement necessary? If "Yes" give dates	From _____ Year:____ Thru _____ Year:____ From _____ Year:____ Thru _____ Year:____ Yes <input type="checkbox"/> No <input type="checkbox"/> From _____ Year:____ Thru _____ Year:____
9 To your knowledge, does patient have other health insurance or Health plan coverages? If "Yes" identify	Yes <input type="checkbox"/> No <input type="checkbox"/>

REMARKS

DATE	SIGNATURE (ATTENDING PHYSICIAN)	DEGREE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	PROVINCE	POSTAL CODE