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INJURY REPORT

Date of Occurrence		Time of Occurrence		Date Reporting Occurrence	
Location of Occurrence (ball park or facility, city)		Owner of the Premises Where Injury Occurred		Person in Charge at Time of Occurrence	
		Permit Holder's Name (if applicable)			
Name of Injured Person		Age	Sex	Address	City
Name of Injured Person's Parent or Guardian if under 18		Address		Postal Code	Telephone
Role of injured party (player, coach, spectator, etc.):		Part of Body Injured		What happened to cause the injury?	
Describe Injury:					
First aid (what steps were taken immediately following the incident)?					
Further Treatment – hospital or doctor's attention required?			Was parent/guardian called? if so, who?		
Was the patient transported for medical treatment? if so, by what means (ambulance, parent/guardian's vehicle, etc.)?			What medical facility was the patient treated at?		
Who treated the patient (name of doctor/dentist, etc.)?			Any other information to report?		
Name of Person Submitting This Report:			Position with Association:		
Email Address:			Telephone #:		

SPORT ACCIDENT CLAIM FORM

Full name of Insured Person (member) _____

Date of Birth (mm/dd/yyyy) _____ Male / Female _____

Mailing Address including City and Postal Code _____

Contact Person if claimant is a minor (parent or guardian) _____

Home Phone _____ Daytime Phone Number: _____

Email address _____

Date of Accident _____

Location of Accident _____

Describe in detail how the accident occurred _____

Type of Injury _____

Name of Doctor/Dentist _____

Address of Doctor/Dentist _____

Do you have other benefits provided under any other insurance plan? _____

If yes, please provide name of Insurer and policy number (certificate) _____

I hereby certify that all information provided in this accident form is correct.

Claimant/Guardian signature _____ Date _____

Certificate of Team Manager / Association or Club Executive:

Name of Team/ League/Association _____ Wentworth Arenas _____

Policy Number _____ Was the player a member at the time of the accident? _____

Was the injury during a sanctioned game or practice? _____

Name _____ Position _____

Signature _____ Phone number _____

Date _____

See Instruction Page for further details on submitting claims



PHYSICIAN'S STATEMENT

Please complete this form and return to patient. Patient's accident claim cannot be processed without the completed Physician Statement

Name of Patient _____

Date of Birth (mm/dd/yyyy) _____ Male / Female _____

Mailing Address including City and Postal Code _____

Date of first visit _____

Complete description of the injury and your diagnosis

If hospital was required, give name of facility _____

Date admitted _____ Discharge date _____

Name of referring physician, if any _____

Physician Name _____

Signature _____

Address _____

Date _____

ACCIDENT CLAIM FORM INSTRUCTIONS

- ⇒ AJ Gallagher Canada, Ltd. must receive notification of your accident within 30 days of it occurring and receive your claim form within 90 days of the accident.
- ⇒ Complete attached Sport Accident Claim Form and Physician Statement. If your claim is for dental injury have your dentist complete and submit a Predetermination Form.
- ⇒ Claims Forms can be submitted to our office electronically or by fax. If you are submitting the forms by mail, please forward copies only and retain originals for your files.
 - AJ Gallagher Canada, Ltd.
435 McNeilly Road, Suite 103
Stoney Creek, ON L8E 5E3
Attention: Sports and Recreation Department
Phone: 1-800-461-5087 Ext 122 Fax: 905-643-8321
Email: sportsadministrator@pearsondunn.com
- ⇒ If you intend to make a claim but have not had out of pocket expenses to date, complete and submit claim form indicating that receipts are to follow.
- ⇒ If you have questions regarding submission of forms, please contact AJ Gallagher Canada, Ltd's Sports and Recreation Department.