

ALLSPORT ATHLETIC ACCIDENT CLAIM FORM

Gymnastics Saskatchewan Inc.

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SECTION I (please print)		
Last Name of Claimant	First Name	Birth Date
Mailing Address		
City	Province	Postal Code
If a Minor, Name of Parent		
Home Phone ()	Business Phone ()	

SECTION II	
Date of Accident	Hour a.m. / p.m. (circle one)
Location of Accident	
What is the injury?	
Date of First Treatment	
Name of Hospital taken to	
Date of Admittance	Hour a.m. / p.m. (circle one)
Date of Discharge	Name of Attending Physician or Dentist

SECTION III Describe fully how the accident happened.

SECTION IV (your sport accident policy is an excess accident benefits policy; proof of exhausting all other insurance must accompany your expenses) What medical coverage do you have through your/spouse/parent employment?				
Name of Employer		Name of Insurer		
Address of Employer		Address of Insurer		
City	Prov.	Postal Code	Policy No.	Certificate Number

SECTION V	
I hereby certify that all the information provided above is correct.	
Claimant's / Guardian's Signature	Date

CERTIFICATION OF ASSOCIATION OR CLUB EXECUTIVE (FOR GYM SASK COMPLETION ONLY)	
Name of Team	League or Association
Accident Policy No. ACL6042	Type of Sport
Was the above player registered at the time of the injury? Yes/No (circle one)	
Was the player injured while taking part in an authorized activity? Yes/No (circle one)	
Name	Position with Club
Telephone No.	Signature

ATTENDING PHYSICIAN'S STATEMENT

Please complete this claim form and return it to your patient.

Patient's Name: _____ Age: _____

Address: _____

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated:

If Hospitalized, give name of hospital: _____

Date Admitted: _____ Discharged: _____

If referred to you, give name of referring physician: _____

Operations (or other procedures performed): _____

	Date: _____
	Date: _____
	Date: _____

Date of first consultation for above: _____

Date of first symptoms: _____ Date of Accident: _____

Has the patient ever had same or similar condition? _____

If yes, please state when and describe: _____

Is there any other disease or infirmity affecting the present condition?

Date: _____ Signature _____ (M.D.)

Address: _____

Certified Specialist _____

Phone: _____