P.W.S.A. ACCIDENT REPORT FORM

Associated (Non-Affiliated Teams)

PLEASE PRINT

COMPLETE IN TRIPLICATE

1. NAME AND ADDRESS OF INJURED PARTY:

NAME: _____

ADDRESS: _____

_____

CITY PROVINCE POSTAL CODE PHONE # (WITH AREA CODE)

TEAM NAME: _____ ASSOCIATION: _____

2. NAME OF PARENT/GUARDIAN, IF INJURED PARTY IS A MINOR:

_____

3. DATE OF ACCIDENT: _____

4. LOCATION OF ACCIDENT: _____

5. EVENT: _____

6. DESCRIBE HOW ACCIDENT HAPPENED: _____

_____

_____

_____

7. SUSPECTED INJURY: _____

_____

8. DO YOU SUSPECT INJURY TREATMENT WILL EXCEED WHAT IS PAID FOR BY YOUR ONTARIO HEALTH PLAN AND/OR DENTAL PLAN? YES: _____ NO: _____

_____

Please print and sign name of Team Coach or Manager Date

PLEASE RETURN TWO (2) COPIES OF THIS COMPLETED FORM TO:

DEBBIE DEMOEL
PWSA INSURANCE CO-ORDINATOR, ASSOCIATED TEAMS
50 CAPRI STREET
THOROLD, ON
L2V 4S8

Official Use Only:

Date Received

Date Medical/Dental Claim Form forwarded to injured party