



# 2019 P.W.S.A. Accident Report Form



This form must be completed in full and emailed to your Divisional Co-ordinator within 14 days of the accident. Failure to submit an accident form within 14 days will result in any subsequent claims not being processed.

## Name and Address of Injured Party

Name:		Email:	
Address:			
City:	Province:	Postal Code:	Phone:

Team Name:		P.W.S.A. Division and Tier:	
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## Name of Parent/Guardian, if injured party is a minor

Name:		Relation:	
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## Accident Details

Date:		Location:	
Event:			

Describe How Accident Happened:

Describe How Accident Happened:	
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Suspected Injury:		Suspected Concussion?	<input type="checkbox"/>
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Do you suspect injury treatment will exceed what is paid for by your Ontario Health / Dental Plan?	<input type="radio"/> Yes <input type="radio"/> No
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Name of Team Coach or Manager	Date
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## Electronic Signature Consent (enter name and check the consent box)

Name:	
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By checking here  , the Parties are consenting to the use of their electronic signature in lieu of an original signature on paper.

## P.W.S.A. Official Use Only

The above listed team member is a registered player of the P.W.S.A.

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Date Received

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Divisional Co-ordinator / Tournament Chairperson

Date Accident Report emailed to Injured Party:	
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Date Accident Report emailed to P.W.S.A. Treasurer:	
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## Concussion Protocol

Date PWSA Return to Play Protocol Received:	
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Date Medical Clearance Received:	
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