

IIHF CHAMPIONSHIP PROGRAM

Pre-Event Medical and Nutritional Questionnaire

Please complete the following questionnaire and have it returned electronically to the IIHF Medical Committee Secretary in Zürich - Switzerland, two (2) months to the beginning of the WM, one (1) month prior to the beginning of all other Championships.

CHAMPIONSHIP: 2025 IIHF _____

LOCATION: _____

DATES: _____

OC Office Contact (Name): _____

Phone: _____

E-Mail: _____

1. Please provide the following about your Chief Medical Officer for the Championship:

Name: _____

Telephone: _____

E-mail: _____

2. Is the Medical Room in the arena?

- | | | |
|--|---------|--------|
| 1. directly beside the ice surface? | Yes ___ | No ___ |
| 2. more than 50 meters from the ice surface? | Yes ___ | No ___ |
| 3. in a different building? | Yes ___ | No ___ |

3. Is the Medical Room appropriately equipped as described in the relevant IIHF Event Code and IIHF Medical Guidelines?

Is there one treatment table in the Medical Room? Yes ___ No ___

Are there two or more treatment tables in the Medical Room? Yes ___ No ___

- Is a cooler or refrigerator available in the Medical Room? Yes ___ No ___
- Is the Medical Room equipped with a defibrillator? Yes ___ No ___
- Is the Medical Room equipped with resuscitative equipment? Yes ___ No ___
- Will there be a defibrillator in the players bench area? Yes ___ No ___

Please find a full list of all requirements for the Medical Room in the relevant IIHF Event Code and IIHF Medical Guidelines (to be found in the IIHF Toolbox).

4. Please describe the medical and therapy services available (please indicate with a check mark P where applicable):

Service	Present at all games	Present at all practices	On-call
Physician			
Dentist			
Orthopedic surgeon			
Emergency physician			
Massage therapist			
Psychologist			
Chiropractor			

5. Please describe the medical service for IIHF Officials, Staff and media:

- Physician at event hotel: Yes ___ No ___
- Physician on-call: Yes ___ No ___

6a. Please confirm the presence of an ambulance for all games and full practices (please indicate with a check mark P):

Service	During all games	During all practices
Ambulance on site		

6b. Please indicate the ambulance cost (add currency) per day and hour:

6c. Contact details of the responsible person for full practice ambulance cancellation (min. 48 hours prior) :

Mr/Mrs /Ms

Last Name: _____ First Name: _____

Mobile Phone number: _____

Email address : _____

7. Are the ambulances equipped with:

Full resuscitative equipment: Yes ___ No ___

Staff trained in basic life support: Yes ___ No ___

Staff trained in advanced life support (intubate, deliver basic emergency meds, etc): Yes ___ No ___

Defibrillator: Yes ___ No ___

Is an Emergency Kit according to the IIHF Medical Guidelines available? (see attached) Yes ___ No ___

8. Have you created a medical manual for team personnel? Yes ___ No ___

9. Is your EAP attached to this questionnaire? Yes ___ No ___

Attached is a sample EAP.

10. Please describe your communication system for the Championship.

Medical staff have mobile phones: Yes ___ No ___

Arena medical staff have mobile radios: Yes ___ No ___



11. Please describe the pharmacy service for your event.

On-site pharmacy with emergency medications: Yes ___ No ___

On-site pharmacy with extensive medications: Yes ___ No ___

Local pharmacy available during normal hours: Yes ___ No ___

Local pharmacy available after normal hours: Yes ___ No ___

No banned substances in event pharmacy: Yes ___ No ___

Banned substances in pharmacy appropriately coded: Yes ___ No ___

Name, addresses, opening hours and telephone number of local pharmacy: _____

Name, addresses, opening hours and telephone number of after-hours
pharmacy: _____

12. Please describe the dental services available at your event.

Dentist present at all games: Yes ___ No ___

Dentist available on-call: Yes ___ No ___

Chief Dentist: _____

Mobile number of Chief Dentist: _____

13. Please provide the following information about the hospital service that will be available during the Championship.

Name of primary hospital: _____

Distance from main arena: _____

Transport time from main arena: _____

Name of secondary hospital: _____

Distance from main arena: _____

Transport time from main arena : _____

14. What arrangements are in place for payment for hospital and diagnostic services?

Hospitals and clinics will accept insurance forms and arrange to collect payment from insurance. Yes ___ No ___

Hospitals and clinics will require direct payment (cash or credit card) when any service is provided. Yes ___ No ___

15. Please describe the diagnostic services available at your event.

X-ray available in the arena: Yes ___ No ___

X-ray available at local hospital: Yes ___ No ___

MRI available at local hospital: Yes ___ No ___

CT available at local hospital: Yes ___ No ___

16. Is tap water drinkable without risk of infection? Yes ___ No ___

If your answer is no, please make sure there is plenty of bottled water available at games and practices as well as the hotel and answer the following two questions:

Will there be plenty of bottled water available at the arena? Yes ___ No ___

Will there be plenty of bottled water available at the hotel? Yes ___ No ___

17. Have you worked with the hotel to create a nutritional menu for the Championship based on the suggested IIHF Nutritional Menu?

Yes ___ No ___

You can find the Nutritional Standards from different continents under Art. X of the IIHF Medical Guidelines which can be found in the IIHF Toolbox.

Please forward a copy of your confirmed hotel menus to the IIHF office.

18. Do teams traveling to your country need any special vaccines?

Yes ___ No ___

If YES, please describe in detail below:

19. Please answer the following questions regarding the doping control room for the Championship.

Is the doping control room within the arena? Yes ___ No ___

Does it have a lockable door? Yes ___ No ___

Does it have a lockable refrigerator for storing the samples? Yes ___ No ___

Does it have a private toilet (big enough for also a witness)? Yes ___ No ___

Does it provide a separated waiting room for the number of people indicated in the respective Event Code? Yes ___ No ___

Does it have a refrigerator for sealed non-alcoholic drinks? Yes ___ No ___

Have you arranged for chaperones or assistants at the event? Yes ___ No ___

20. Please provide the name of your Event Integrity Officer if it is not your MNA Integrity Officer:

Name: _____

Telephone: _____

E-mail: _____

Please review the *IIHF Abuse & Harassment Regulations*.

[2024_iihf_abuse_harassment_regulations.pdf](#)

List of attachments:

- *Emergency Kit*

- *EAP*