

ATTENDANT CARE
DISABILITY CERTIFICATE

I, _____, have examined and/or treated
_____, for injuries sustained in a motor vehicle accident on
_____. It is my opinion that as a result of the injuries received in this
accident, the aforementioned patient needs help with all or some of the following:

- | | |
|--|--|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Dressing |
| <input type="checkbox"/> Styling/combing of hair | <input type="checkbox"/> Help using the toilet |
| <input type="checkbox"/> Ambulation | <input type="checkbox"/> Fetching things for the patient |
| <input type="checkbox"/> Carrying and lifting things for patient | <input type="checkbox"/> Supervision for safety reasons |
| <input type="checkbox"/> Administering medications | <input type="checkbox"/> Changing bandages |
| <input type="checkbox"/> Wound Care | <input type="checkbox"/> Shaving beard/legs |
| <input type="checkbox"/> Brushing teeth | <input type="checkbox"/> Cooking for the patient |
| <input type="checkbox"/> Driving the patient | <input type="checkbox"/> Nail clipping |
| <input type="checkbox"/> Applying make-up | <input type="checkbox"/> Monitoring infections |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

It is my opinion that the patient (is/was) disabled and in need of **ATTENDANT CARE** as described above from _____ to _____. The patient needs help _____ days a week at _____ hours per day.

Doctor signature

Dated: _____

Address

AFFIDAVIT OF ATTENDANT CARE SERVICES PERFORMED

Name _____

Address _____

Telephone Number _____ Social Security Number _____

Occupation _____ Relationship to Insured _____

Services performed: _____

Dates and/or Hours Worked _____

Charge per hour _____ Total _____

Have you provided services prior to date of accident? _____

I declare the above information to be true and accurate and above services were performed as indicated.

(signature of party performing services) (date)

(signature of insured) (date)