ATTENDANT CARE
DISABILITY CERTIFICATE

I, ________________________________, have examined and/or treated
(Name of Doctor)

____, for the following injuries/diagnosis codes
(Name of Patient)

____

____

____

sustained in a motor vehicle accident on ______________________. It is my opinion that as a
(Date of accident)

result of the injuries received in this accident, the aforementioned patient needs help with all or some of the following:

> **"ACTIVITIES OF DAILY LIVING"** such as Bathing, Dressing, Ambulation, Styling/combing of hair, Help using the toilet, Carrying or lifting things for the patient, Assisting with medication, and Supervision for safety reasons.

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 each week at ___________ hours per day.

____
Doctor's signature

____
Address

DATED: ____________________