REPLACEMENT SERVICES
DISABILITY CERTIFICATE
$20.00 PER DAY MAXIMUM

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 is disabled from doing:

(Please check all that apply)

☐ 1) "Housework" as some housework may involve bending, lifting, twisting, and prolonged standing as required by changing linens; making beds; washing floors, sinks, bathtubs, toilets; moving furniture; picking up objects off floor; carrying garbage, etc.

☐ 2) "Caring for patient's children" which may involve bending, lifting, twisting and prolonged standing as required by changing children's clothes; bathing children, cooking for children; feeding children; cleaning and straightening up after children, etc.

It is my opinion that the patient (is) (was) disabled as described above from

______________ to ______________. The patient needs help __________ days a week.

____
Doctor's Signature

Dated: ____________________

____
Address

HOUSEHOLD SERVICES STATEMENT

Your Name: ______________________________

Service Providers Name: ______________________________

Service Providers Address: ______________________________

Providers Telephone Number: ______________________________

Social Security Number: ______________________________

Describe specifically what services were provided:

A. Vacuuming
B. Dusting
C. Cooking
D. Dishwashing
E. Making Beds
F. Ironing
G. Laundry
H. Changing Linens
I. Snow Shoveling
J. Grass Cutting
K. Grocery Shopping
L. Taking Out Garbage
M. Driving (destination and mileage)
N. Running Errands (be specific)
O. Child Care
P. Home Repairs (be specific)
Q. Window Washing
R. Misc: ______________
S. ______________
T. ______________

Indicate on the following calendar what services by letter were performed on which dates:

MONTH: ______________

1.	2.	3.	4.	5.	6.	7.
8.	9.	10.	11.	12.	13.	14.
15.	16.	17.	18.	19.	20.	21.
22.	23.	24.	25.	26.	27.	28.
29.	30.	31.				

Providers Signature: ______________________________ Date: ______________