# 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:

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

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

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# 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)