AFFIDAVIT OF ATTENDANT CARE RENDERED

Injured Party: _____ Claim Number: _____

Injuries: See Medical Records

Provider Name: _____

Provider Address: _____

Services Provided:

A. Observation/Supervision
B. Assist with clothing/dressing
C. Assist with bathing/grooming
D. Assist with toileting
E. Daily Appointment/Agenda Planning Assistance
F. Driving/Providing Transportation/Attend appointments
G. Assist with all activities of daily living
H. Assist with home exercises/physical therapy
I. Assist with cognitive exercises/therapy
J. Monitor/administer medication
K. Meal preparation / cooking
L. Changing of linens/bedding
M. Wound care/bandage change
N. Assist with transfers
O. On-call time
P. Other: _____

MONTH - _____

Date:	Hours	Service(s)	Date:	Hours	Service(s)
1st			17th		
2nd			18th		
3rd			19th		
4th			20th		
5th			21st		
6th			22nd		
7th			23rd		
8th			24th		
9th			25th		
10th			26th		
11th			27th		
12th			28th		
13th			29th		
14th			30th		
15th			31st		
16th					

I spent the above number of hours on the dates listed above performing the services indicated. As of today, I have not been paid for the services performed despite having provided them with the expectation of payment. I have read this statement and swear it to be true.

Dated: _____ _____ _____

Provider Signature Provider Signature