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 Mobility / Walking
C. Assist with Transfers
D. Assist with Bathing / Showering
E. Assist with Personal Grooming

F. Assist with Clothing / Dressing
G. Assist with Toileting
H. Attend / Assist to Medical Appts.
I. Assist with Feeding
J. On-Call / Supervision Time

K. Assist with Home Exercises / PT
L. Assist with Cognitive Exercises / Therapy
M. Wound Care / Bandage Change
N. Daily Appt / Agenda Planning Assistance
O. Monitor / Remind / Dispense Medicine
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