

AFFIDAVIT OF ATTENDANT CARE RENDERED

Injured Person: _____

Care Provider: _____

1. Name: _____

2. Address: _____

3. Phone No.: _____ - _____ - _____

4. Soc Sec No: _____ - _____ - _____

Attendant Care Services Provided

- | | |
|--|--------------------------------|
| A. Safety Supervision | J. Eating / Meal Preparation |
| B. Ambulation Assistance | K. Medication Management |
| C. Transferring / Positioning | L. Management of Finances |
| D. Emotional Assistance | M. Bandage / Wound Care |
| E. Bathing Assistance | N. Hygiene Assistance |
| F. Dressing Assistance | O. Physical Therapy Assistance |
| G. Grooming Assistance | P. Other _____ |
| H. Toileting Assistance | _____ |
| I. Transportation Needs / Medical Appt | |

Work Performed: On the following calendar, please indicate the services by letter and the dates on which those services were performed.

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

5. I have spent _____ hours per day, _____ days per week performing these services.

6. Have you provided these services prior to the accident? _____

7. **Agreement / Compensation** - As of today, I have not been paid for the services performed that I expect to be paid \$ _____ per hour.

I declare the above information to be true and accurate as the above services were performed as indicated.

Signed: _____ Date: _____

