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

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

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

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:**