ATTENDANT CARE FORM

Injured Name: _____

Claim Number: _____ Date of Loss: ____ / ____ / ____

Service Providers Name: _____

Service Providers Address: _____

Telephone Number: (_____) _____

Describe specifically what services were provided and time required per day to perform the tasks:

a. Therapy Program
b. General Supervision
c. Assist to Bathroom/Elimination
d. Driving to doctor appointment
e. Administering Medications
g. Assist with Hygiene/Bathing/AM care
h. Change Bandages
i. Physical Therapy
j. Night Assistance/Bathroom, turning, etc.
l. On-call Care
k. Other _____

Indicate on the following calendar what services (by letter from the above chart) were performed on which dates as required:

Month: _____ Year: _____

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

Pursuant to an agreement, I provided the above care and expect to be paid for the attendant care described above.

Service Provider Signature: _____ Date: _____

Claimant Signature: _____ Total Hours: _____