ATTENDANT CARE STATEMENT

Claimant: _____

Claim No: _____ Date of Loss: ____/____/_____

Service Provider's Name: _____

Service Provider's Address: _____

Telephone Number: _____ Social Security 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.	Assistance with	E.	Administering Medications	F.	Assist with Hygiene/Bathing/AM Case
G.	Change Dressings	H.	Physical Therapy	I.	Night Assistance/Bathroom/Turning
J.	Other _____				

Indicate on the following calendar what services (by letter from the above chart) were performed on which dates and time as ordered by physician.

MONTH _____ YEAR _____

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

SIGNATURE OF PROVIDER: _____ DATE: _____