



ATTENDANT AFFIDAVIT

Re: _____
Veteran's Name – Last, First, Middle

VA Claim or Social Security Number

Claimant's Name

Claimant's Address (Street)

City, State and Zip Code

My name is _____, and I provide health care for the above named claimant.

The services which I provide are:

- Yes No Assistance with bathing
- Yes No Standing and sitting
- Yes No Getting in and out of bed
- Yes No Eating
- Yes No Walking
- Yes No Dressing and undressing
- Yes No Taking medication
- Other: (Please describe)

For these services, I am paid by the claimant _____ per week / month / year (please circle only one).

I began employment on _____.

Signature of provider

Street Address

City, State, and Zip Code

Phone number (including area code)

I CERTIFY, under the penalty of law, that the above information is true and correct, that I do pay the above referenced sitter the amount listed for the services listed. (If claimant signs with his/her mark, the mark must be witnessed by two witnesses.)

Signature: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____