



## 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: \_\_\_\_\_