REPLACEMENT SERVICES
DISABILITY CERTIFICATE
$20.00 PER DAY MAXIMUM

I, _____, have examined and/or treated
(Name of Doctor)

_____, for injuries sustained in a motor vehicle accident
(Name of Patient)

on _____.
(Date of Accident)

It is my opinion that as a result of the injuries received in this accident, the aforementioned patient is disabled from doing: (Please check all that apply)

_____ 1) "**Housework**" as some housework may involve bending, lifting, twisting, and prolonged standing as required by changing linens; making beds; washing floors, sinks, bathtubs, toilets; moving furniture; picking up objects off floor; carrying garbage, etc.

_____ 2) "**Caring for patient's children**" which may involve bending, lifting, twisting and prolonged standing as required by changing children's clothes; bathing children, cooking for children; feeding children; cleaning and straightening up after children, etc.

It is my opinion that the aforementioned patient (is)(was) disabled as described above

from _____ to _____. The patient needs help 7 days per week.

_____
Doctor's Signature

Dated: _____

_____
Address