MEDICAL STATEMENT FOR AID & ATTENDANCE
(Please circle the appropriate answer and **explain in detail**)

Veteran or Surviving Spouse's Address: VA File # (if applicable)

_____ _____

_____

_____

Veteran's Name: _____

Claimant's Name: _____

1. Complete Diagnosis: _____

_____

_____

2. Is the claimant able to walk unaided? **Yes** **No**

Explanation:_____

_____

3. Is claimant able to feed himself/herself? **Yes** **No**

Explanation:_____

_____

4. Does claimant need assistance bathing or with other hygiene needs? **Yes** **No**

5. Is claimant able to care for the needs of nature? **Yes** **No**

Explanation:_____

_____

6. Is the claimant confined to bed? **Yes** **No**

Explanation:_____

_____

7. Is the claimant able to sit up? **Yes** **No**

Explanation:_____

_____

8. Is the claimant blind? **Yes** **No**

Explanation:_____

_____

9. Is the claimant able to travel? **Yes** **No**

Explanation:_____

_____

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10. Can the claimant leave home unassisted? **Yes** **No**
(If so, how far can he/she go? Estimate distance)

Explanation:_____

_____

11. Does claimant require nursing home care? **Yes** **No**

Explanation:_____

_____

12. In your opinion are there pertinent facts, which show the claimant's need for daily assistance and aid & attendance?

Explanation:_____

_____

*** If possible attach copies of office or medical records concerning claimant's medical history ***

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT
Physician's name & address (please type or print)

_____ _____
(Examining Physician's Signature)

_____

_____