THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

Medical Record Attestation Form

Member information
Member first name
Member last name
Date of birth

Issuer information
Issuer name
Issuer HIOS ID
Date of service

Attestation

To be completed by physician/practitioner

I, _____ *(print full name of the physician/practitioner)*, hereby attest that the above listed individual requires custodial care for the following:

☐ Bathing

☐ Dressing

☐ Eating, cooking

☐ Transferring

☐ Toileting/Continence

☐ Transportation

☐ Home upkeep

☐ Other *(please specify)* _____

_____

_____

This accurately reflects observations/notations I made in my capacity as _____ *(insert provider credentials, e.g., M.D.)* when I treated/diagnosed the above listed individual. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Provider signature: Date *(mm/dd/yyyy)*

Complete and email this form to the Board of Pensions at memberservices@pensions.org.
Questions? Call the Board at 800-773-7752 (800-PRESPLAN).