

# City of Columbia Personal Care Attendant Registration

1. Your Name: \_\_\_\_\_

2. Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

3. Telephone number (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

4. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

5. Person to be attended:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone number (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

6. In what capacity do you know the person to be attended: \_\_\_\_\_

\_\_\_\_\_

7. Are you in position to make decisions concerning medical treatment for the person to be attended? ( ) Yes ( ) No

If no, then who is: \_\_\_\_\_

8. I hereby certify that the information given here is correct.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Attendant's signature)

9. Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Attendee's Signature)