PO Box 923
Lincroft, NJ 07738

Underwritten by
Twin Lights Insurance Company

SERVICE RESTRICTION CHECKLIST

Insured:
Injured Party:
Claim Number:
Policy Number:
Date of Loss:

Please print or type all information requested and sign where indicated.

	Service	Can Do	Can Do with Limitations	Anticipated Release Date	Cannot Do
1)	Vacuum/sweep				
2)	Dust				
3)	Wash/laundry				
4)	Iron/laundry				
5)	Cook				
6)	Wash dishes				
7)	Wash floors				
8)	Mow lawn				
9)	Rake leaves				
10)	Shovel snow				
11)	Clean bathroom				
12)	Child care				
13)	Wash windows				
14)	Take out garbage				
15)	Other: _____				
16)	*Other:* _____				
17)	Other: _____				
18)	Other: _____				

- This patient will need help with household chores a total of _____ hours a week.
- Length of time these restrictions apply: _____

Please explain the patient's physical limitations:

Signature: _____ **Date:** _____