



PO Box 900  
Lincroft, NJ 07738

High Point Preferred Insurance Company  
 High Point Safety and Insurance Company  
 High Point Property and Casualty Insurance Company  
 Palisades Safety and Insurance Association  
 Palisades Insurance Company  
 Palisades Property and Casualty 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) <i>Other:</i>    | _____  | _____                   | _____                    | _____     |
| 17) <i>Other:</i>    | _____  | _____                   | _____                    | _____     |
| 18) <i>Other:</i>    | _____  | _____                   | _____                    | _____     |

- 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:** \_\_\_\_\_