UNION UNIVERSITY HEALTH SERVICES
EQUIPMENT RENTAL AGREEMENT

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ PH# _____

UU ID#: _____

I hereby acknowledge receipt of the following item(s) of medical equipment loaned to me by Union University Health Services for the applicant's sole use and that this equipment will not be loaned to anyone else. I acknowledge that this equipment will be used as it is designed to be used, and I will exercise ordinary and reasonable care thereof.

EQUIPMENT RENTED: ____ CRUTCHES ____ WHEELCHAIR ____ MOTORIZED WHEELCHAIR

RENTAL DATE: _____ RETURN DATE: _____

By signing below I acknowledge that (please initial each line):

____ I have examined the equipment and that I find it in good condition and fit for its intended use.

____ I promise to return the equipment by the date listed above.

____ In consideration of future borrowers, I promise to clean and sanitize the equipment prior to returning it.

____ I acknowledge that if the equipment is not returned, or not returned in the same condition as it was at the time of rental, I will be charged ($50 crutches) ($250 wheelchair) ($1,500 for motorized wheelchair) the replacement cost of such item(s).

Patient Signature _____ Date: _____

Union University Health Services _____ Date: _____

UNION UNIVERSITY
HEALTH SERVICES

For office use only

Date Returned: _____ Condition:_____

Charge to account: _____