Serving Our Communities

MEDICAL EQUIPMENT BANK LOAN & LIABILITY AGREEMENT

BUSINESS SIGN-IN

We loan out donated supplies and equipment to those in need, you are required to return equipment when no longer needed. **ITEMS ARE NOT TO BE RE-SOLD**. **You are responsible for damage and repairs at your own cost.**

USE OF ITEMS IS AT YOUR OWN RISK. THERE IS NO GUARANTEE IMPLIED OR GIVEN ON BORROWED ITEMS

THIS FORM MUST BE FILLED OUT COMPLETELY BEFORE YOU CAN REMOVE ITEMS FROM THE MEDICAL EQUIPMENT

SUPPLIES/EQUIPMENT IS FOR

DATE:	PRINT FIRST AND LAST NAME SUPPLIES/EQUIPMENT ARE FOR:	PHONE:	ITEMS TAKEN:
ADDRESS:	APT #: / CITY: / ZIP CODE:		
EMAIL ADDRESS: (Optional)	BIRTHDATE (mm/dd/yyyy):	NEWSLETTER: ☐ ALREADY RECEIVING ☐ LIKE TO RECEIVE	FIRST TIME TO THE MEB? ☐ YES ☐ NO
DO YOU HAVE MEDICAL INSURANCE? ☐ YES ☐ NO	☐ MEDICADE-NAME OF INSURANCE: _____ ☐ MEDICARE-MANAGE CARE/SECONDARY:_____		
CHECK ALL THAT APPLY: ☐ Veteran ☐ 60+ ☐ Disabled	Please enter combined YEARLY income for the home $_____ Donation $_____		
I AUTHORIZE THE BELOWED NAMED PERSON/BUSINESS TO PICKUP MY SUPPLIES/EQUIPMENT.	SIGNATURE (YOUR ID IS REQUIRED):		RETURN DATE OF EQUIPMENT:

PERSON PCKING UP

THIS AREA IS FOR THE REPRESENTIVE FROM THE FACILITY/AGENCY/BUSINESS

☐ Facility Caregiver ☐ Agency Caregiver ☐ Own Business (ID REQUIRED)	PRINT FIRST AND LAST NAME OF REPESENTIVE PICKING UP SUPPLIES/EQUIPMENT:	Donation From Business: $_____

FACILITY/AGENCY/ADULT FAMILY HOME:	ADDRESS:	CITY:	ST:	ZIPCODE:
FACILITY EMAIL:	PHONE:	SIGNATURE:		

WE DO NOT SHARE/SELL YOUR INFORMATION