

Professional Consultation for Durable Medical Equipment

|  |  |
| --- | --- |
| Customer Name: | Agency/Contact Name: |
| Address: | Address: |
| City,State,Zip: | City, State,Zip: |
| Phone:  | Phone |

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ accept responsibility for evaluating and properly fitting

 (Professional Name/Number)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Equipment Name/Mode/Size) (Client Name)

Deliver the device to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Professional Signature/Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **I agree to use the equipment is accordance with the instructions received from the professional consultant and I further agree to hold Saving Our Seniors harmless of any liability or damage related to the use of the equipment.**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Return form to: Saving Our Seniors

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727-537-6753 Fax: 727-499-7171

Director@savingourseniors.care