Saving Our Seniors

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
752 24th Ave N. St. Petersburg FL 33704
727-537-6753 Fax: 727-499-6783
Director@savingourseniors.care