VISITING NURSES FOUNDATION

Application for Visiting Nurses Foundation Grant
Return Medical Equipment to Visiting Nurses Thrift Store at
360-623-1562 or 360-623-1560 222 S. Pearl Street, Centralia, WA,98531

MISSION STATEMENT

The Mission of the Visiting Nurses Foundation is to create funding for education and assistance of Home Health and Hospice patients and their families.

Equipment Bank Loan Application

HOW DID YOU HEAR ABOUT OUR MEDICAL EQUIPMENT BANK? _____

Patient Name: _____ **DATE:** _____

Patient Address: _____ **County:** _____

City: _____ **State:** _____ **Zip:** _____

Patient Signature : _____ **Patient Phone:** _____ — _____ — _____

Contact Name & Responsible Party: _____

Contact Address: _____

City: _____ **State:** _____ **Zip:** _____

Contact Signature: _____ **Contact Phone:** _____ — _____ — _____

How long do you expect to have the items out on a loan: _____

Specify how the Medical Equipment will be utilized to help you or the patient.

_____

_____

Indemnity Agreement

It is agreed that the undersigned shall indemnify and hold harmless Visiting Nurses Foundation/Assured Home Health & Hospice Foundation, its' successors, assigns and insurer from any and all liability, damages, claims, expenses and attorney fees of any kind, including damages for bodily injury and/or property damage caused by or resulting from any item or piece of equipment loaned for their use or in any way distributed by Visiting Nurses Foundation/Assured Home Health & Hospice Foundation.

_____

Signature of Patient or Person Acting as Agent for Patient **Date**

_____

Employee Signature **Date**

LOAN AGREEMENT

I, _____ **agree to the terms as follows: I know the equipment is a loan. I will not sell, trade, transfer to another individual or company, or alter the equipment in any way. I will return the Medical Equipment to the Visiting Nurses Foundation when I no longer need it. If the equipment is in disrepair while in my care, I will return the equipment to the foundation so that they can repair it after evaluation.**

_____

Signature of Patient or Person Acting as Agent for Patient **Date**

Medical Bank Customer Service & Foundation Use Only:
Check ID and ADDRESS

Approved: **Yes** **No**
Verified: ☐

Revised:4/16

Executive Director/Employee Approval: _____ **Date Checked out:** _____

Print Executive Director/Employee: _____ **Date Returned:** _____

Item: _____ **Inventory #** _____ **$:** _____

Item: _____ **Inventory #** _____ **$:** _____

Item:_____**Inventory #**_____**$:**_____

Item:_____**Inventory #**_____**$:**_____

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