



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

Employee Signature **Date**