WHEELCHAIR LOAN

PLATTE COUNTY PUBLIC HEALTH

718 9TH STREET, WHEATLAND, WYOMING (307) 322-2540

Borrower must initial on each line and complete all contact information:

_____ In consideration of being permitted to **BORROW** the following wheelchair from Platte County Public Health's Loan Closet. I do hereby release and forever discharge Platte County, and any employee of Platte County, from any and every claim due to any injury that may be sustained from using the borrowed equipment, either through negligence or by accident.

_____ I understand and agree that **WHEELCHAIRS ARE ONLY LOANED FOR ONE MONTH. I UNDERSTAND THESE ARE FOR LOAN ONLY; NOT FOR ME TO KEEP.** If I find I need the wheelchair for use longer than one month, it is my responsibility to make arrangements to rent or purchase the needed items **from a medical supply company** during the one month loan period. Because this is a service meant to benefit residents of the entire county, **ITEMS CANNOT BE BORROWED FOR LONGER THAN ONE MONTH.** I agree that I will return the **WHEELCHAIR IN ONE MONTH OF THE DATE THEY ARE BORROWED.** If I do not return the wheelchair, Public Health will contact me about arranging the return or replacement.

_____ Public Health's Loan Closet services are only for residents of Platte County, Wyoming. **Deposits may be required for items taken more than 10 miles outside of Wheatland. Staff will notify you if a deposit is required**.

Deposit Amount: _____ Paid by (cash/check): _____ Received by:_____

_____ This item was presented to me clean and in working order. I agree to return it in a similar manner. I understand that if I return the item, either dirty or damaged, or if I fail to return***, I will be required to pay the replacement cost of the item and will not be allowed to borrow any items from the Loan Closet in the future***. **THE COST OF THE WHEELCHAIR IS $500.00**.

Equipment Pre-Check (Client/Staff Initials) _____/_____ Comments: _____

Equipment Post-Check (Client/Staff Initials) _____/_____ Comments: _____

_____ I have received a copy of this agreement.

Today's Date: _____Item due back to Public Health: _____ Nurse/Staff initials: _____
(One Month from Date)

Name of person who needs the wheelchair: _____

Address: _____Phone: _____
(Please include city, state & zip code)

Wheelchair Sticker ID#_____ Comments_____

_____

Please understand if you are borrowing items on behalf of another individual, that by signing below, you are obligating yourself personally responsible for the return of the wheelchair or replacement of $500.00

Responsible Person's Name (Printed)_____

Responsible Person's Signature: _____

Borrower's Contact Information, if different than above: Address: _____Phone: _____
(Please include city, state & zip code)

Updated 6/22/2023