



Charles County Dept. of Community Services
Aging & Senior Programs Division
Medical Equipment Loan Closet
301-934-9305, ext. 5103

CHECKOUT DATE: _____

Please fill out the information below for the person who will be using the equipment.

RECIPIENT'S NAME: _____

ADDRESS: _____

PHONE NUMBER: _____ EMAIL: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

Please check all that apply:

Marital Status: [] Married, [] Widowed, [] Divorced, [] Separated, [] Single

Race: [] White, [] African-American, [] American Indian/Alaskan, [] Asian, [] Hawaiian/Pacific Islander, [] Other

Ethnicity: [] Hispanic, [] Non-Hispanic

Gender: [] Male, [] Female

Number of people in household: _____

[] If the person who is checking out the equipment is not the end user fill in additional information below.

CARE GIVER'S NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

EMAIL ADDRESS: _____

RELATIONSHIP TO RECIPIENT: _____

EQUIPMENT REQUESTED: _____

ANTICIPATED LENGTH OF LOAN: _____

(RENEWAL OF LOAN REQUIRED AFTER 90 DAYS)

** I understand that the medical equipment that is on loan from the Charles County Department of Community Services/Aging Division is not transferrable. The equipment must be returned in clean, working condition by:

X

Signature of person checking out equipment

Date

OFFICE USE ONLY

Returned Date: _____ Items Returned: _____

Staff signature and comments: _____