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:_____