Tri-County Medical & Ostomy Supplies, Inc.
1904 Knob Creek Rd., Suite 1
Johnson City, TN 37604
Phone: 423-282-6933 or 800-228-3682 Fax: 423-282-8270

EQUIPMENT COMPREHENSION TRAINING FORM

Recipient's Name:_____

Address: _____

Equipment Received: Wheelchair / Walker / Cane or Quad Cane / Crutches / Commode Chair / Bathroom Aids / Other

Serial Number: _____ Make/Model: _____

Date Equipment Received and manufactures manual provided: _____

Recipient's statement:
I certify that I have received the equipment listed above for my own personal use. I understand & agree that I am responsible for taking care of the item(s) furnished to me for as long as they are assigned to me. I also understand that insurance will not pay for repair of the equipment due to misuse, abuse or loss, whether intentional or unintentional.
I certify that a qualified representative of Tri-County Medical & Ostomy Supplies, Inc. has provided training/ education to me or family member/ responsible party concerning care and safe use of this equipment to include:

- PURPOSE OF EQUIPMENT
- USE OF EQUIPMENT
- SAFETY PRACTICES TO USE WITH EQUIPMENT RECEIVED
- RETURN DEMO ON PRODUCT
- CONTACT INFORMATION FOR TRI-COUNTY MEDICAL PROVIDED
- PURCHASED ITEMS WARRANTY, SERVICE & CARE OF EQUIPMENT EXPLAINED
- SAFETY PRECAUTIONS
- CLIENT RIGHTS & RESPONSIBILITIES
- MEDICARE STANDARDS (IF APPLIES)
- EMERGENCY PROCEDURES

By signing this I certify that I have been instructed and understand how to use the above equipment and I understand the information that has been provided to me. I understand that Tri-County Medical & Ostomy Supplies, Inc. will not be held responsible in any way for damage or personal injury that may occur to me or someone else that uses this piece of equipment.

_____ _____
Signature of recipient/ family/ responsible party Date

_____ _____
Signature of Tri-County Medical & Ostomy Supplies Date