**Health Care Device Contract:**

Offender Name: Offender #: Institution:

I am being issued:
 Equipment Type: Product / Model: Size:

 Serial ID #: Model: Issue Date:

[ ]  Permanent Issue [ ]  Temporary Issue (Return date for temporary issue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

I understand that I share in the responsibility to keep the health care appliance listed above in good working order by using it only for its intended purposes.

I will not allow other offenders to use this health care appliance.

I understand that I must immediately report any issues concerning damage of this health care appliance to by submitting a Request for Medical Care. DOC is responsible to initiate repair or replacement of the equipment within 30 days of receipt of my sick call request indicating there is a problem with the equipment.

I understand that, if the preponderance of the evidence shows that I altered, cut on, damaged, or destroyed this equipment, I will be responsible for the replacement cost of the equipment. In this event, I may request replacement of the same equipment at my own cost. Arrangements for payment will need to be made in advance. If I am unable to pay the cost of replacement, that cost will be charged to my inmate account.

I understand that if I misuse, alter, cut on, or otherwise damage or destroy this health care appliance, I will face discipline.

I understand that if I use this health care appliance inappropriately as outline above, my use of this assigned health care appliance may be limited, restricted, or removed.

Offender Signature: Date:

Offender Printed Name:

Clinical Services Employee Signature: Date:

Clinical Services Employee Printed Name:

Original: Medical File

Cc: Institution Property Officer