VALLEY MEDICAL SUPPLIES
Living Independently

VMS Staff Only

Equipment # ____________________

Due Back : ______________________

Staff Initial : _____________________

PLEASE FILL OUT COMPLETELY

Name : ____

Credit Card #: ____

All agreements will be secured during the day, and shredded at night!

Expires: __________________

Address: ____

Zipcode: __________________

Phone: ____

Email: ____

If you would like an receipt for the rental

VMS Staff Only

Type (circle) Scooter Wheelchair Stroller Wagon

Length (circle) <4Hours Full Day

Total Charge ___________________________

Paid (circle) Cash Credit Card

If Late (circle) Late Charge Owed

Rental Authorization

Printed Name: ____

Signature: ____

Date: ____________________________

By signing this form, I acknowledge that I have read the rental agreement and understand the terms and conditions set forth herein.

Renter authorizes Valley Medical Supplies LLC to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. Renter certifies that they are the authorized user of this credit card and will not dispute the payment with credit card company; so long as the transaction corresponds to the terms indicated in this agreement.

Renter assumes all risk of such loss or damage and waives all claims against Valley Medical Supplies LLC by reason thereof and Renter agrees to hold Valley Medical Supplies LLC harmless from and to defend and indemnify Valley Medical Supplies LLC against all claims based upon or arising out of such loss or damage.

Renter understands that if the rented equipment is not returned on the agreed upon return date/time(due back), additional charges will be incurred.

Renter understands if equipment is not returned by the end of hours of operation, a late fee or up to the full amount of rental equipment will be charged as the equipment will be considered lost or stolen.