



Educational Audiology/Speech
Pathology Resources For Schools

An outreach program of Arkansas Children's Hospital

Loaner Equipment Program Agreement Form

DATE: _____

STUDENT NAME: _____

DISTRICT/SCHOOL: _____

DEVICE(S): _____

DEVICE SERIAL NUMBER(S): _____

Please initial by each line and sign at bottom.

_____ The *School/District* understands that they are borrowing property of the EARS Program.

_____ The *School/District* understands that the loaner program is for temporary use only.

_____ The *School/District* understands that it is their responsibility to maintain and keep up with the device(s).

_____ The *School/District* understands that if the device(s) are lost or damaged, the school/district may not be eligible to receive additional device(s) from the loaner bank and may be responsible for replacement costs.

Signatures:

We agree to the provisions of this agreement and indicate by our signatures our commitment to the terms described in this agreement.

Representative of the School District

Date

EARS Audiologist

Date