DW Medical Supply, Inc.

1524 Centinela Ave. Inglewood, CA 90302
Telephone: (310) 330-0162 Fax: (310) 330-0199

DELIVERY TICKET

Date of Delivery	
Delivered To:	
Patient's Name	
Address	
City State Zip	
Phone	

	ITEM(S) SUPPLIED	QTY	MFG NAME	MODEL	SERIAL #
1					
2					
3					
4					
5					
6					
7					

I, the undersigned, have received the equipment and/or supplies as identified above and accept in good working condition. **I have been fully instructed in the safe and proper use and operation of the equipment and/or supplies. I have demonstrated to the delivery technician my ability to use the equipment and/or supplies. I witnessed all safety checks performed by the service technician and have been advised of the applicable warranties.** I have been provided the name and telephone number of **DW Medical Supply, Inc.** and/or service technician to contact regarding the care, operation or service of the equipment and/or supplies received. **DW Medical Supply, Inc.** is not responsible for damage to the equipment or supplies as a result of misuse, modification by me or my designee. **Assignment of Benefits**: I reassign Health Care Benefits to be made on my behalf to **DW Medical Supply, Inc.** for all equipment, supplies or services furnished to me by **DW Medical Supply, Inc.**. **Authorization for Release of Information**: I authorize **DW Medical Supply, Inc.** to release medical or other information necessary to process insurance claim(s).

Patient's Signature: _____ Date: _____

Print Name: _____

☐**Check if Authorized Representative signed and dated above.** Relationship: _____

Patient demonstrated knowledge of proper and safe operation of the equipment and/or supplies delivered.

Technician's Signature: _____ Date: _____

Print Name: _____