

University of Minnesota
Lions Infant Hearing Program

Loaner Hearing Aid Bank Agreement

Audiologist : _____

Borrowing Facility: _____

Patient Information

Patient: _____ D.O.B.: _____

Parents/Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (H): _____ (W): _____

Email: _____

**The Lions Infant Hearing Program and the University of Minnesota
have loaned to the above-named individual the following hearing aid (s):**

Manufacturer: _____ Model: _____ Serial #: _____ ID: _____

Manufacturer: _____ Model: _____ Serial #: _____ ID: _____

Please initial each statement and sign below.

_____ I agree that my child will receive a loaned hearing aid(s) from the Lions Infant Hearing Program and the University of Minnesota.

_____ I agree that my child will have use of this/these hearing aid(s) for up to 6 months.

_____ I agree to seek permanent hearing aid(s) and/or medical treatment during this loan period for my child.

_____ I agree that when my child receives his/her personal hearing aids, I will return the loaned hearing aid(s) to my child's audiologist.

Parent/Legal Guardian

Signature: _____ Date: _____

* Please Retain in Patient's Records *

Please complete missing information and fax to Loaner Bank at 612-~~625-8901~~ ⁸⁹⁰¹