Rental Contract

Brent1@Txdme.com

Ticket Number _____

Credit Card Holder Information

Credit Card Holder Name:

_____

Credit Card Holders Billing Address:
Address House number City State, and Zip

_____

Credit Card Holders
Phone Number _____

Credit Card Holders Signature X_____

Delivery Information

Equipment Requested: Patient Height_____ and Weight _____

_____

Equipment Rental Time Requested (Week or Month)

_____

Equipment Rental Rate and Deposit Paid

_____

Start the rental on (Mon-Friday)_____
End the rental on (Mon-Friday)_____
Delivery address for the rental equipment

_____

Delivery Phone Number

_____

Pick-up address for the rental equipment (if same please indicate)

_____

Pick-up Delivery Phone Number

_____

Please complete the above information, so that we can process your rental request
** Please either email or Fax completed form and we will send a conformation email **
Orders in by 2:00pm will be delivered next Business day between 12:00pm and 4:00pm
Deposits will be credited upon return of the rental equipment
Damaged ,Lost or missing items on from the equipment will be charged against the deposit

Initials Indicate acceptance of the Rental agreement (_____)