LIMBS FOR LIFE FOUNDATION

Clinic Partner: _____

Clinic Phone: _____

Clinic Address: _____

_____

Clinician: _____

Delivery Acknowledgement

Patient Acknowledgement:

I _____, acknowledge that on _____ I received my completed
Patient Name *Date*
socket and/or componentry utilized in the fabrication of my prosthesis. I am satisfied with both the workmanship and fit of my prosthetic device, and I will call the clinic partner contact listed above to schedule a return visit if I experience problems with my device or if I have any questions regarding my care.
I understand the following:

- The socket is fully guaranteed under normal use **for the provided warranty period of the clinical partner or for 90 days**, whichever period is longer.
- The clinical partner will make any repairs to my device, as needed, free of charge during the warranty period.
- It is the responsibility of the clinical partner to conduct regular follow up care and adjustments as needed for the life of the device.
- Any changes in my physical weight, condition, or any other physiological changes that may occur, may cancel this agreement.
- Any alterations to the device made by anyone other than the clinical partner may void the warranty.
- Neither the clinical partner nor Limbs for Life will be held responsible for abuse, neglect, or abnormal normal wear and tear of my device.

I hereby authorize the clinical partner to request on my/our behalf and to collect any awarded funds (if authorized by Limbs for Life) for the products and/or services supplied to me:

_____ _____
Patient Signature *Date*

Clinician Acknowledgement:

I _____, acknowledge that starting on _____ my
Clinician name *Date*
current clinic of employment: _____, understand that the socket provided today is fully guaranteed under normal use until _____. I agree to make any repairs
Warranty Expiration Date
to the device, as needed, free of charge during the warranty period. I also agree to conduct regular follow up care and adjustments as needed for the life of the device.

_____ _____
Clinician Signature *Date*

A copy of this completed document will be included in the patient's delivery paperwork, and included in clinic records. The original document will serve as proof of delivery and will accompany the final invoice and photos, upon completion of the prosthetic device:

Limbs for Life Foundation: 9604 N. May Ave, Oklahoma City, OK 73120 or admin@limbsforlife.org
Phone: 405-843-5174 / 888-235-5462 Fax: 405-843-5123