Arizona WIC Program
Multiple User Double Electric Breast Pump Release Form

Family ID#: _____

Participant's Name (Mom): _____

Address: _____

City/State/Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Alternate Contact Person: _____

Relationship: _____

Phone Number: _____

_____ I am currently enrolled in the Arizona WIC Program and will continue enrollment by keeping my WIC appointments.

_____ I understand that it is my responsibility to inform the WIC clinic of any change of address or phone number.

_____ I have received instruction on assembly, use, disassembly, and cleaning of the breast pump and the storage and handling of expressed breast milk.

_____ I understand that the Arizona Department of Health Services, the Arizona WIC Program, and its employees are not responsible for any personal damage caused by the use of this breast pump. I am the only one responsible.

_____ I understand that it is my responsibility to protect the breast pump from theft and loss. I will handle the breast pump with care. I will keep the breast pump in a secure area at all times.

_____ I understand that, if the breast pump breaks or malfunctions, I must return the pump to the WIC clinic for replacement or repair.

_____ I understand that I am the only one authorized to use this pump. I will not loan or sell this pump to anyone.

_____ I understand that this breast pump is the property of the Arizona WIC Program and, as State property, I must return it to the WIC clinic by the due date or pay the WIC Program back for the cost of the pump (up to a maximum of $400.00).

WIC Participant Signature: _____ Date: _____

Issuer (WIC Staff): _____ Title: _____

Date to be returned: _____ Date issued: _____

Issuing Local Agency/Clinic: _____ Breast Pump Serial Number: _____