

## *Breast Pump Distribution Agreement*

### **Participant Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Alternate Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Message Phone: \_\_\_\_\_

WIC ID Number: \_\_\_\_\_

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**Type of pump received?**     manual pump  
   electric pump attachment kit  
   electric pump

**Received pump for?**         problems with engorgement  
   separation from baby  
   missed feeding for school or work  
   mother/baby is ill

**Review completed?**         pump assembly  
   pump cleaning  
   pump use  
   plans for using pump

**Will pump be returned?**     yes  
   no

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### **Participant must read and sign below.**

- I have received the breast pump as indicated above.
- The proper use of the breast pump has been explained to me and I fully understand its proper use.
- I agree not to bring any claim against the Oregon WIC Program or its affiliates, County Health Department or government, State of Oregon, or any official or employee connected with this program for any damages or expenses arising from use of the breast pump.
- I have received a copy of this form.
- I have read the above information and understand it.

\_\_\_\_\_  
(Participant Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Staff Signature)

\_\_\_\_\_  
(Date)