Newborn Hearing Screening Equipment Responsibility Agreement

I, ______________________________, hereby request privileges to use the newborn Otoacoustic Emissions (OAE) hearing screening equipment for the purpose of screening infants for hearing loss, who were born within the scope of my professional practice.

I am a: ___ Licensed Midwife ___ Certified Nurse Midwife

I recognize that the equipment is property of the Wyoming EHDI Program and is being issued to me for the sole purpose of providing newborn hearing screening in accordance with the provisions of Wyoming Statute 35-4-801. I agree to use this equipment consistent with the use for which it is intended.

I agree to report the screening results to the Wyoming EHDI Program via the Wyoming EHDI System within 10 days of screening, in the form and manner prescribed by the Program.

I agree to immediately return the OAE screening equipment to the Wyoming EHDI Program, in the event that I should close my practice, lose my license to practice in the State of Wyoming, and/or for any reason am no longer attending births in the State of Wyoming.

I understand that I am liable for serious damages or loss of the equipment while the equipment is in my possession. If the equipment malfunctions, or if I suspect a malfunction, I will promptly contact the Wyoming EHDI Program.

If the hearing screening unit is being under-utilized or used improperly, the screening unit will be removed from my possession and the Wyoming EHDI Program will re-disperse the screening equipment as appropriate.

I understand that signing this Responsibility Agreement is a prerequisite to using this newborn hearing screening equipment. I understand that in order to use this equipment, I and any other midwives who intend to use the hearing screening equipment must have attended the Wyoming EHDI training, or an equivalent training. I agree to the terms, conditions, and obligations stated above in this Responsibility Agreement.

Signed: ________________________________ Date: ______________________

Name: _________________________________ Phone: ____________________

Witness Signature: ________________________________ Date: ____________________

Printed Witness Name: __________________________________

Midwife Address:____

____ Zip Code: _________________

E-mail address: ________________________________

License Number:______________________________

OAE screening unit Equipment Serial #: ____

Which counties to do you practice in: ____

Other practitioners assigned to use this equipment (OAE screening unit):

1. Name: ____
   Phone: ____
   License number: __________________________________
2. Name: ____
   Phone: ____
   License number: __________________________________
3. Name: ____
   Phone: ____
   License number: __________________________________