**SPHM – Equipment Inventory Form**

<table>
<thead>
<tr>
<th>Facility Name:</th>
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<tbody>
<tr>
<td>Address:</td>
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<td>Date:</td>
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<tr>
<td>Contact:</td>
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<tr>
<td>Administrator:</td>
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Floor_______ Unit ______ of ________

Total Resident/Patient Capacity Possible for this unit/floor: ________________________________

**Current Number of Sit-to-Stand on Unit/Floor:** ________________________________

Brand: ________________________________  Condition: ________________________________

Storage Location: ________________________________

Charging Station: ________________________________

**Current Number of Total Assist Lifts on Unit/floor:** ________________________________

Brand: ________________________________  Condition: ________________________________

Storage Location: ________________________________

Charging Station: ________________________________

**Current Number of Ceiling Lifts:** ________________________________

Brand: ________________________________  Condition: ________________________________

**Current Number of Friction Reducing/Lateral Transfer Devices Available:** ________________________________

Brand: ________________________________  Condition: ________________________________

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Our safety evaluations, reports and recommendations are made solely to assist your organization in reducing hazards and the potential of hazards and accidents. These recommendations were developed from conditions observed and information provided at the time of our visit. They do not attempt to identify every possible loss potential, hazard or risk, nor do they guarantee that workplace accidents will be prevented. These safety evaluations, reports and recommendations are not a substitute for ongoing, well-researched internal safety and risk management programs. This report does not warrant that the property inspected and its operations are compliant with any law, rule or regulation.

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