This form must be mailed d Board <i>of</i> Orthotists & Pros 4052 Bald Cypress Way, Bi Tallahassee, FL 32399-3258	n C-08		PORTHOTISTS & PROSTHETIS
Board <i>of</i> Orthotists &	& Prosthetists		*
Registration Superv	isor Update Form		* FLORIDA
Select <u>one</u> option from each	a category:		
Profession: Orthotist (310	9) Prosthetist (3110)	Dual Orth	otist & Prosthetist (3111)
Program: Internship	Residency		
1. PERSONAL INFORMATIO	N		
Name:			Registration #:
Last/Surname	First	Midd	
Street/P.O. Box		Apt. No.	
State	ZIP Country	1	Home/Cell Telephone
Email Address:			
			il address released in response to public ce. Instead contact the office by phone or in
2. PRACTICE INFORMATION	4		
Current Supervisor:			
Supervisor Name			Florida License Number
New Supervisor:			
Supervisor Name			Florida License Number
Name of Practice			Practice Telephone
Practice Street Address		City	State ZIP
Date Internship/Residency St	arts: MM/DD/YYYY	Date Internsh	ip/Residency Ends: MM/DD/YYYY

3. EXPLANATION OF WORK EXPERIENCE AND REASON FOR EARLY TERMINATION OF SUPERVISION (Attach an additional sheet if necessary)

4. SUPERVISOR / INTERN / RESIDENT AFFIRMATIONS

SUPERVISOR

I agree to supervise the referenced resident/intern in accordance with the requirements set forth in Rule 64B14-4.100, Florida Administrative Code (F.A.C.). The above information is true and correct.

Supervisor Signature

Date (MM/DD/YYYY)

INTERN/RESIDENT

I agree to abide by the laws and rules of the state of Florida and to follow the direction of my supervisor in accordance to the requirements set forth by Rule 64B14-4.100, F.A.C. I further agree that if this supervision is terminated for any reason, I shall inform the board in writing within thirty business days.

I, _____, certify the above information is true and correct.

Print Name

Internship/Residency Applicant Signature

Date (MM/DD/YYYY)