This form must be mailed directly to the board office at:

Board of Orthotists & Prosthetists

4052 Bald Cypress Way, Bin C-08 Tallahassee, FL 32399-3258

Board of Orthotists & Prosthetists **Registration Supervisor Update Form**



Select <u>one</u> op	otion from each cate	gory:				
Profession:	ession: Orthotist (3109)		Prosthetist (3110)		Dual Orthotist & Prosthetist (3111)	
Program:	Internship	Residency				
PERSONAL	_ INFORMATION					
Name:					Registration #:	
Name: Last/Surname		First	First		Middle	
Mailing Addr	ess: (The address wh	ere mail and yo	our license s	hould be se	nt)	
Street/P.O. Bo	эх			Apt. No.	City	
State		ZIP	Country		Home/Cell Telephone	
- -mail ∆ddress	S:					
writing.	INFORMATION	il address or sen	d electronic m	ail to our offic	ce. Instead contact the office	by phone or ir
Supervisor Na	ame	 			Florida License	e Number
New Supervis	sor:					
Supervisor Na	ame				Florida Licens	e Number
Name of Practice				Practice Telephone		
Practice Stree	et Address		С	ity	State	ZIP
Date Internship/Residency Starts:				Date Internship/Residency Ends:		
		MM/DD/YYYY	•		MM	/DD/YYYY

6. EXPLANATION OF WORK EXPERIENCE AND F (Attach an additional sheet if necessary)	REASON FOR EARLY TERMINATION OF SUPERVISION
I. SUPERVISOR / INTERN / RESIDENT AFFIRMAT	FIONS
SUPERVISOR I agree to supervise the referenced resident/intern in Florida Administrative Code (F.A.C.). The above info	n accordance with the requirements set forth in Rule 64B14-4.100, ormation is true and correct.
Supervisor Signature	Date (MM/DD/YYYY)
INTERN/RESIDENT	
	Florida and to follow the direction of my supervisor in accordance F.A.C. I further agree that if this supervision is terminated for any y business days.
I,Print Name	, certify the above information is true and correct.
Internship/Residency Applicant Signature	Date (MM/DD/YYYY)