Name: _____

6. SUPERVISOR INFORMATION

This section to be completed by Resident Applicant's Supervisor

_____

Supervisor Name | Florida License Number | ABC Certification Number*

_____

Name of Practice | Practice Telephone

_____

Practice Street Address | City | State | ZIP

Date Residency Starts: _____ (MM/DD/YYYY)

Date Residency Ends: _____ (MM/DD/YYYY)

**American Board for Certification in Orthotics, Prosthetics, & Pedorthics, Inc. (ABC)*

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

_____ _____

Supervisor Signature | Date (MM/DD/YYYY)

7. RESIDENT STATEMENT

I agree to abide by the laws and rules of the state of Florida and to follow the direction of my supervisor in accordance with 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 30 business days.

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

_____ _____

Residency Applicant Signature | Date (MM/DD/YYYY)