



## ACTIVITY PLAN/SUPERVISORY PLAN

Print clearly in black ink or type the following information:

**ASSISTANT'S NAME** \_\_\_\_\_ **SOCIAL SECURITY#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Check one:  Full-Time  Part-Time    Check one:  Speech-Language Pathology Assistant  Audiology Assistant

<b>I. SUPERVISOR DATA</b>	
Supervisor's Name:	Business Phone:
Supervisor's License Number:	<input type="checkbox"/> Speech-Language Pathology <input type="checkbox"/> Audiology
<b>II. ACTIVITY/SUPERVISORY DATA</b>	
<b>NOTE:</b> The activity plan <u>must</u> be in compliance with 64B20-4.003 and 64B20-4.004, F.A.C.	
Activity to be performed by Assistant	How activity will be supervised
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

I affirm that my assistant and I have reviewed, together, Chapter 468, Part I, Florida Statutes, and Chapter 64B20-4, Florida Administrative Code. I fully understand my responsibilities to my assistant and to the Board and Department as a registered supervisor of a certified assistant.

**Supervisor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Turn over if necessary)

**Assistant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

DH-SPA-3 Revised 5/09 Reference 64B20-4.001 (2) F.A.C.

Activity to be performed by Assistant	How activity will be supervised
7.	7.
8.	8.
9.	9.
10.	10.
11.	11.
12.	12.
13.	13.
14.	14.
15.	15.
16.	16.
17.	17.
18.	18.

DH-SPA-3 Revised 5/09 Reference 64B20-4.001 (2) F.A.C.

**Supervisor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Assistant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_