



TERMINATION OF SUPERVISION OF AN OCCUPATIONAL THERAPIST ASSISTANT  
Please enter required information, sign and date at the bottom of the page. Email or Fax form back.

Responsible Occupational Therapist: \_\_\_\_\_  
First Middle Last

License No.: - \_\_\_\_\_

Occupational Therapy Assistant: \_\_\_\_\_  
First Middle Last

License No.: - \_\_\_\_\_

Practice Address: \_\_\_\_\_  
Address  
\_\_\_\_\_  
City State Zip

Practice Phone Number: - \_\_\_\_\_

Effective Date: / / \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Responsible OT)