Assistive Technology Implementation Plan

Student ____________________

Team Members

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Date of Plan: ____________________

Assistive Technology Device: ____________________

Review Date: ____________________

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Support Task	**Person(s) Responsible**	**Schedule**	**Evidence of Completion**
Initial Student Training			
Ongoing Student Training			
Daily/Regular Support of Student Use			
Daily/Regular Maintenance Activities			
Staff Training			
Consultation with Staff			
Communication with Family			
Parent/Family Training			
Repairs and Modifications			