Assistive Technology Implementation Review 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	Date	Summary
Current Student Performance			
Repair/Maintenance			
Update Current Device (yes/no)			
Modification of Device			
Additional Training (yes/no)			
New Device (yes/no)			