

WATI Assistive Technology Trial Use Guide

AT to be tried: _____

Student's Name: _____ DOB: _____ Age: _____ Meeting Date: _____

School/Agency: _____ Grade/Placement: _____

Contact Person(s): _____

School/Agency Phone: _____ Address: _____

Persons Completing Guide: _____

Parent(s) Name: _____ Phone: _____

Parent(s) Address: _____

Goal for AT use: _____

ACQUISITION

Source(s)	Person Responsible	Date(s) Available	Date Received	Date Returned

Person primarily responsible to learn to operate this AT: _____

Training

Person(s) to be trained	Training Required	Date Begun	Date Completed

MANAGEMENT/SUPPORT

Location(s)	Support to be provided (e.g. set up, trouble shoot, recharge, program, etc.)	Person Responsible

Student Use

Date	Time Used	Location	Task(s)	Outcome(s)