Corrective Action Plan

Employee's Name (please print or type) _____

Division/Unit _____

CCPS Employee ID No. _____

Evaluator's Name (please print or type) _____

Employee's Signature/Date _____

Evaluator's Signature/Date _____

Corrective Action Plan	
Beginning Date	
Projected End Date	
Objective(s) Needing Improvement	
Targeted Area(s) of Improvement	
Actions the employee will take	
Support/Resources the evaluator will provide	
Timeline	
Data/Evidence for Review	

Corrective Action Plan Status **To be completed at the projected end date*	☐ *Completed* ☐ *Extended* ☐ *Not Completed*