



Corrective Action Plan

Name: _____

Date of Plan: _____

Review Date of Plan: _____

Area of Focus:	
Goal 1:	
Expectation:	
Required Actions:	
Criteria for Success:	
Supports:	

Area of Focus:	
Goal 2:	
Expectation:	
Required Actions:	
Criteria for Success:	
Supports:	

Educator's Signature	Educator's Printed Name
Administrator's Signature	Administrator's Printed Name
Union Representative's Signature	Union Representative's Printed Name

Outcome(s) from Corrective Action Plan	
☐	Significant progress was noted after at least 30 days. The teacher will return to a lower level of support.
☐	Minimal progress was noted after at least 30 days. A meeting will be held between the educator, administrator, a collective bargaining representative and Central Office administrator to determine next steps.