



Level 3: Intensive Support 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 Level 3 Intensive Support	
☐	Significant progress was noted after at least 30 days. The teacher will return to a lower level of support.
☐	Some progress was noted after at least 30 days. The teacher will continue on a Level 3 Intensive Support Plan.
Date of Review of Progress Toward Growth Target:	
☐	Minimal progress was noted after at least 30 days. The educator will be moved to a Corrective Action Plan