Deficiency Improvement Action Plan

Name of Teacher:_____

Name of Administrator:_____

Date: _____

Area(s) of need of improvement: State the specific CSTP:

Methods that will be used to improve:

Resources need to improve:

Name of support staff to help improvement:_____

Date of next evaluation: _____

I have read the above report. My signature does not necessarily denote agreement.

Signature of Evaluatee _____ Date _____

Signature of Evaluator _____ Date _____