HERNANDO COUNTY SCHOOL DISTRICT

CORRECTIVE ACTION PLAN

Employee Name_____ Employee I.D. _____

Employee Title _____ Location _____

The following performance deficiencies have been identified: _____

_____

_____

_____

_____

Action Plan: _____

_____

_____

_____

_____

Target date for next review: _____

Notate if employee is asking for assistance and type requested:_____

_____

Administrator completing form (printed):_____Title: _____

Administrator signature:_____ Date:_____

Employee signature:_____Date:_____

RESULTS:

☐ All deficiencies have been corrected

☐ All deficiencies have not been corrected

☐ Employee made some progress and will be placed again on a Corrective Action Plan for another 30 calendar days

☐ Employee made progress and will be reassessed in 90 calendar days

☐ Employee has not satisfactorily met expectations and has been put on notice that employment action will be taken (ie. demotion, recommendation for nonreappointment, termination)

Comments:_____

_____

Administrator completing form (printed):_____Title:_____

Administrator signature:_____Date:_____

Employee signature:_____Date:_____