

TEN-DAY CORRECTIVE ACTION PLAN - STAGE1

There are a variety of circumstances leading to a Ten-Day Corrective Action Plan for Clinical Experiences. Prior to implementing a Ten-Day Corrective Action Plan, the University Supervisor must communicate with the cooperating teacher, and/or school officials, and the Clinical Intern to discuss the rationale for a plan.

Some guidelines for implementing a Ten-Day Corrective Action Plan include:

- If after the second observation, but no later than the third observation, the Clinical Intern is receiving consistent *Does Not Meet Expectation* in the same indicators, a Ten-Day Corrective Action Plan should be implemented.
- If after the midterm evaluation, the Clinical Intern received more *Does Not Meet Expectation* than *Meets Expectation*, a Ten-Day Corrective Action Plan should be implemented
- If there is an immediate area(s) of concern by the Cooperating Teacher, district/school official and/or supervisor, a Ten-Day Corrective Action Plan should be implemented

TEN-DAY CORRECTIVE ACTION PLAN SEMESTER 2 OF CLINICAL PRACTICE STAGE 1

Clinical Intern's Name:*

Banner ID:*

Course # and Title:

Placement (School / District):

STAGE 1

PRIOR TO IMPLEMENTING A TEN-DAY CORRECTIVE ACTION PLAN, THE UNIVERSITY SUPERVISOR MUST COMMUNICATE WITH THE COOPERATING TEACHER, AND/OR SCHOOL OFFICIALS, AND THE CLINICAL INTERN TO DISCUSS THE RATIONALE FOR A PLAN.

#1 Observation/Evaluation Date:*

MM / DD / YYYY



Please submit the completed observation, evaluation, or professional disposition that has triggered the necessity of the Ten-Day Corrective Action Plan.*

+ Select File(s)

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THERE IS AN IMMEDIATE AREA OF CONCERN BY THE COOPERATING TEACHER, DISTRICT/SCHOOL OFFICIAL AND/OR SUPERVISOR PROMPTING A TEN-DAY CORRECTIVE ACTION PLAN IMPLEMENTATION.

☐ Yes

☐ No

Additional Comments:

#2 Observation / Evaluation Date:*

MM / DD / YYYY



Please submit the completed observation, evaluation, or professional disposition that has triggered the necessity of the Ten-Day Corrective Action Plan.*

+ Select File(s)

Drag and drop file here

THERE IS AN IMMEDIATE AREA OF CONCERN BY THE COOPERATING TEACHER, DISTRICT/SCHOOL OFFICIAL AND/OR SUPERVISOR PROMPTING A TEN-DAY CORRECTIVE ACTION PLAN IMPLEMENTATION.

☐ Yes

☐ No

Additional Comments:

#3 Observation / Evaluation Date:

MM / DD / YYYY



Please submit the completed observation, evaluation, or professional disposition that has triggered the necessity of the Ten-Day Corrective Action Plan.

+ Select File(s)

Drag and drop file here

THERE IS AN IMMEDIATE AREA OF CONCERN BY THE COOPERATING TEACHER, DISTRICT/SCHOOL OFFICIAL AND/OR SUPERVISOR PROMPTING A TEN-DAY CORRECTIVE ACTION PLAN IMPLEMENTATION.

☐ Yes

☐ No

Additional Comments:

OFFICE OF CLINICAL EXPERIENCES NOTIFICATION

Has the Office of Clinical Experience been notified of the Ten-Day Corrective Action Plan is being initiated?*

- ☐ Yes
- ☐ No

Will the Clinical Intern require a new Field Placement?

- ☐ Yes
- ☐ No

[Update](#)

[Cancel](#)

TEN-DAY CORRECTIVE ACTION PLAN - STAGE2

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TEN-DAY CORRECTIVE ACTION PLAN SEM2 CLINICAL EXPERIENCE PLACEMENT: STAGE 2

THIS TEN-DAY CORRECTIVE ACTION PLAN IS DESIGNED WITH COLLABORATION OF THE UNIVERSITY SUPERVISOR, COOPERATING TEACHER, AND THE CLINICAL INTERN NAMED ABOVE TO IMPROVE HIS/HER PERFORMANCE IN THE CLINICAL PRACTICE EXPERIENCE. THE PLAN IS INTENDED TO ASSIST SAID CLINICAL INTERNS IN MEETING STANDARD(S)/INDICATOR(S) OF THE *CLINICAL PRACTICE TEACHER CANDIDATE PERFORMANCE EVALUATION RUBRIC*. ALL CLINICAL INTERNS MUST MEET EXPECTATIONS OF ALL INDICATORS PRIOR TO THE END OF THE SEMESTER. THE COOPERATING TEACHER WILL MAINTAIN A DAILY FEEDBACK LOG ON THE CLINICAL INTERN'S PROGRESS WITH EACH PERFORMANCE INDICATOR OF CONCERN, REVIEW IT WITH THE CLINICAL INTERN, AND SEND THAT LOG VIA E-MAIL TO THE SUPERVISOR AND CLINICAL INTERN. AN INFRACTION OF ANY ASPECT OF THIS PLAN WILL REQUIRE AN ELIGIBILITY MEETING ON CAMPUS WITH THE CLINICAL INTERN, SUPERVISOR AND DEPARTMENT CHAIR.

Clinical Intern's Name:*


Banner ID:*

Course # and Title:

Placement (School / District):

STAGE 2

EVALUATION OR REVIEW DATE*

TEN-DAY CORRECTIVE ACTION PLAN REPORT

*



| Ref.# | Performance Indicator(s) of Concern | Evidence of Improvement | Due Dates |
|------------------------------|-------------------------------------|-------------------------|-----------|
| There is no data to display. | | | |

Has an update of this plan been forwarded to the Office of Experiences?*

- ☐ Yes
- ☐ No

TEN-DAY CORRECTIVE ACTION PLAN - STAGE3

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TEN-DAY CORRECTIVE ACTION PLAN PRIOR TO CLINICAL EXPERIENCE PLACEMENT: STAGE 3

Clinical Intern's Name:*

Banner ID:*

Course # and Title:

Placement (School / District):

TEN-DAY CORRECTIVE ACTION PLAN COMPLETION

Date of Meeting with the Office of Clinical Experience*

MM / DD / YYYY



It was determined:*

Acknowledgments:*

+ Select File(s)

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Final Plan Review Date:*

MM / DD / YYYY



It was determined the Ten-Day Corrective Action Plan will:*

- ☐ Continue
- ☐ Dismiss
- ☐ Other

Additional Details

+ Select File(s)

Drag and drop file here

Additional Notes:

Update

Cancel