MOFFAT COUNTY SCHOOLS REMEDIATION PLAN

FORM - G

Employee's Name: _____ _____ **Position:** _____ **Date of Initiation:** _____

Supervisor's Name: _____ **School:** _____ **Date of Completion:** _____

A. Professional Improvement Objectives:

B.

Recommended Improvement Activities	Assistant	Indicators of Accomplishment	Completion Date

Signature indicates participation in planning conference and understanding of the Improvement plan.

_____ _____ _____ _____

Employee Signature Date Administrator Signature Date

Original: Evaluator Copies: Staff Member, Principal, Superintendent Successful completion of this plan does not imply reemployment