**|| PLAN OF ASSISTANCE**

Educator Name:

Date:

School:

Evaluator:

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| 1. Component(s) rated as “Ineffective”: |
| Click here to enter text |

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| 1. Performance deficiencies leading to the “Ineffective” rating: |
| Click here to enter text |

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| 1. Recommendations to correct deficiencies: |
| Click here to enter text |

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| 1. Criteria used to assess the correction of deficiencies: |
| Click here to enter text |

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| 1. Assistance and resources to be provided: |
| Click here to enter text |

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| 1. Members of assistance team (if applicable): |
| Click here to enter text |

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| 1. Timeline for correction of deficiencies: |
| Click here to enter text |

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| --- | --- |
| Date of Next Evaluation: | |
| Next evaluation to be conducted on or before: | Click here to enter text |

My signature verifies that this Plan of Assistance has been discussed with me. I understand my signature does not necessarily indicate agreement and that I may respond in writing regarding this plan within       days of receipt.

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Educator Signature: Date:

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Evaluator Signature: Date: