Department of Human Services
Office of Facilities and Support Services
Corrective Action Plan

Employee: _____ **Date**:_____

Deficiency/Violation Description:

Corrective Action:

Deadline to Cure:

☐ 60-Days Cure _____ ☐ 90-Days Cure _____

Agreement and Signatures

The below parties have discussed the above discrepancy. The employee acknowledges said discrepancy and agrees to the required corrective actions and cure deadlines as detailed in this document.

Employee Signature: _____Date of Signature: _____

Manager signature: _____ Date of Signature: _____