Clinical Practice Corrective Action Plan
PennWest University --- College of Education

If a teacher candidate's clinical practice is deemed unsatisfactory by the university supervisor, the Clinical Practice Corrective Action Plan is completed.

This form is discussed with the Teacher Candidate and is signed by the Teacher Candidate, the University Supervisor, Department Chair, Campus Field Service Coordinator, and the Dean of the College of Education.

Name of Candidate:

Date:

Clinical Practice Observation Dates:

Clinical Practice Competency Domain Being Corrected - The University Supervisor checks all competency domain areas that apply.

_____ Planning and Preparation

_____ Learning Environment

_____ Instructional Delivery

_____ Professionalism (See also the Professional Disposition Action Corrective Action Plan)

_____ Assessment

_____ Knowledge of Diverse Learners

Reason(s) for this corrective action (to be completed by the university supervisor). Add sections as needed.

Plan for Corrective Action (to be completed by both the teacher candidate and university supervisor). List as many goals as appropriate.

GOAL #1:	Action Steps:	Resources and Support:
Goal will be achieved when:		
Supervisor acknowledgement of goal achievement. _____ Goal was met. _____ Goal was not met. Supervisor Signature: Date:	Notes and comments:	
GOAL #2:	Action Steps:	Resources and Support:
Goal will be achieved when:		
Supervisor acknowledgement of goal achievement. _____ Goal was met. _____ Goal was not met. Supervisor Signature: Date:	Notes and comments:	
GOAL #3:	Action Steps:	Resources and Support:
Goal will be achieved when:		
Supervisor acknowledgement of goal achievement. _____ Goal was met. _____ Goal was not met. Supervisor Signature: Date:	Notes and comments:	

Acknowledgement of Corrective Action Plan
(To be completed at the start of the corrective action process)

I acknowledge that the above descriptions of the candidate's clinical practice are accurate, and that a corrective action plan is needed.

University Supervisor Signature:

Date:

Department Chair Signature:

Date:

Campus Field Service Coordinator Signature:

Date:

I understand the goals and agree to complete the action steps listed above. I will use the resources and support to assist me in improving my practice. I also understand that the Corrective Action Plan will be placed in Anthology.

Teacher Candidate Signature:

Date:

Acknowledgement of Completion Signatures
(To be completed at the close of the corrective action process)

_____ I acknowledge that the teacher candidate has satisfactorily met all corrective action goals and will continue with student teaching.

_____ I acknowledge that the student teacher has **NOT** satisfactorily met all corrective action goals.

University Supervisor Signature:

Date:

The results of the success or failure of this corrective action plan have been explained to me.

Teacher Candidate Signature:

Date:

Receipt of Corrective Action Plan and Final Determination

We received the corrective action plan and note the following final determination:

_____ Goals met— Continue with student teaching

_____Goals not met — Exit certification program

_____Goals not met— Fail Student Teaching

University Supervisor Signature and Date:

Department Chair Signature and Date:

Campus Field Service Coordinator Signature and Date:

Dean, COE, Signature and Date: