



**WORK IMPROVEMENT PLAN  
NOTICE OF SUBSTANDARD PERFORMANCE**

State Form 52405 (R / 6-11)

This form is to be used to address and correct performance deficiencies that arise during the performance review period.

Employee Name	Employee Identification Number
Agency / Division	Business Unit
Class Title / Class Code	Starting Date of Plan ( <i>month, day, year</i> ):

Follow Up Date On or Before:       Thirty (30) Days       Sixty (60) Days       Ninety (90) Days

**This does not establish any guarantee of continued employment for any specific time frame. This form documents that you must make immediate improvement in the performance of your duties. Failure to improve your performance to at least a "Meets Expectations" level may result in reassignment, demotion, or termination.**

Initials of the Employee: \_\_\_\_\_

**Description of specific performance deficiencies:**

**Corrective action to be taken:**

Employee's Responsibility:

Manager/Supervisor's Responsibility:

Signature of Evaluator:	Signature of Reviewer:	Signature of Appointing Authority:	Date ( <i>month, day, year</i> ):
Signature of Employee:			Date ( <i>month, day, year</i> ):

***To be completed to document the results of this work improvement plan.***

Successful Completion of Work Improvement Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date ( <i>month, day, year</i> ):	
If No, explain follow up action taken:		
Initials of Supervisor:	Initials of Employee:	Date of Discussion ( <i>month, day, year</i> ):