

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

Employee:	Date:	

**Deficiency/Violation Description**:

Corrective Action:

Deadline to Cure:   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 thi document.	is
Employee Signature:Date of Signature:	

Manager signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_