

**FINAL DETERMINATION**

|  |  |
| --- | --- |
| Employee’s Name: | Click here to enter text. |
|  |  |
| Position: | Click here to enter text. | School/Department: | Click to enter text. |
|  |  |  |  |
| Principal/Supervisor: | Click here to enter text. |
|  |  |  |  |
| Initial Date of Plan of Assistance: | Click to enter a date. |  |  |

The following determination has been made regarding the employee’s completion of the above-referenced Plan of Assistance (please check one):

[ ]  SATISFACTORY

I (employee named above) understand that if at any time within three (3) years of the initial documentation of Unsatisfactory Performance, my performance is determined to be unsatisfactory for any deficiency identified in this Plan, my job can be terminated without an additional Plan of Assistance. \_\_\_\_\_\_\_\_\_ (initial)

[ ]  UNSATISFACTORY

The principal/supervisor will give a signed copy of this document and a letter containing a recommendation to terminate to the Director of Human Resources. Please list deficiencies not corrected in the section below.

**DEFICIENCES NOT REMEDIED**

(Please list and/or attach any documentation or other evidence of deficiencies not corrected supporting the determination that performance remains unsatisfactory.)

|  |
| --- |
| Click here to enter text. |

I have seen and understand the Final Determination above and it has been personally discussed with me.

Employee Signature Date

Principal/Supervisor’s Signature Date

cc: Director of Human Resources

cc: Director of Choose an item.

cc: District Personnel File