Individual Action Plan

Employee Name:
Employee Title:
Department:
Time Period for Action Plan: (60, 90, or 180 days): _____

	Action step/description of area for improvement	Responsible party	Follow-up/ milestones for feedback	Desired outcome
1				
2				
3				
4				
5				
	Consequences/next steps if desired outcomes are not achieved:			

Employee Signature: _____ Date: _____
Supervisor/Reviewer Signature: _____ Date: _____