

REMEDIATION PLANNING MEETING

Date of Remediation Plan Meeting:

Name of Student:

Dissertation Supervisor:

Names of All Persons Present at the Meeting:

Remediation Plan Addresses (please check)

- | | | |
|--|---|--|
| <input type="checkbox"/> Performance in course (specify course) | <input type="checkbox"/> Performance on Practicum (specify course) | <input type="checkbox"/> Performance in Dissertation |
| <input type="checkbox"/> Performance in comprehensive exam | <input type="checkbox"/> Performance in Predoctoral Internship | <input type="checkbox"/> Other (Please specify) |

Please check all competency domains in which the student's performance does not meet the benchmark:

Foundational Competencies:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Professionalism (e.g. meeting obligations/deadlines; motivation, work ethic, attitudes) | <input type="checkbox"/> Reflective practice, Bias evaluation | <input type="checkbox"/> Evidence-based knowledge and methods | <input type="checkbox"/> Interpersonal skills and communication |
| <input type="checkbox"/> Individual, social, and cultural diversity | <input type="checkbox"/> Ethics, Standards, Laws, Policies | <input type="checkbox"/> Interprofessional Practice | <input type="checkbox"/> Self-care |

Functional Competencies:

- | | | | | |
|-------------------------------------|---------------------------------------|-----------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Intervention | <input type="checkbox"/> Research | <input type="checkbox"/> Supervision | <input type="checkbox"/> Consultation |
|-------------------------------------|---------------------------------------|-----------------------------------|--------------------------------------|---------------------------------------|

Description of the problem(s) in each competency domain indicated above:

Date(s) the problem(s) was brought to the student's attention and by whom:

Steps already taken by the student to rectify the problem(s) that was identified:

Steps already taken by the supervisor(s)/faculty to address the problem(s):

REMEDIATION PLAN

| | |
|--|------------------------|
| Objectives/Goals | 1. 2. 3. |
| Student's Responsibilities/ Actions | |
| Supervisors'/ Faculty Responsibilities/ Actions | |
| Plan to Meet Objectives & Goals | 1. 2. 3. |
| Criteria for Goal Attainment | |
| Date When Objectives are to be Met | |
| Consequences for Unsuccessful Remediation | |

I, _____, have reviewed the above remediation plan with my primary supervisor, any additional supervisors/faculty, and the director of clinical training. My signature below indicates that I fully understand the above. I understand that if any portion of my remediation plan is not met by the required deadlines, my student status may be in jeopardy in the PsyD. Program. My comments, if any, are below (*PLEASE NOTE: If student disagrees, comments, including a detailed description of the student's rationale for disagreement, are REQUIRED*).

Student Signature

Date

Student's comments:

All supervisors/faculty with responsibilities or actions described in the above competency remediation plan agree to participate in the plan as outlined above. Please sign and date below to indicate your agreement with the plan.

Director of Clinical Training

Date

Faculty/Supervisor Signature

Date

Faculty/Supervisor Signature

Date

SUMMATIVE EVALUATION OF REMEDIATION PLAN

Follow-up Meeting Date:

In Attendance:

| Objectives/Goals | Criteria for Goal Attainment (met, partially met, not met) | Next Steps (e.g., remediation concluded, remediation continued and plan modified, next stage in Due Process Procedures) | Next Evaluation Date (if needed) |
|-------------------------|--|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| | | | |

I, _____, have reviewed the above summative evaluation of my remediation plan with my primary supervisor(s)/faculty, any additional supervisors/faculty, and the director of clinical training. My signature below indicates that I fully understand the above. My comments, if any, are below. (*PLEASE NOTE: If student disagrees with the outcomes and next steps, comments, including a detailed description of the student's rationale for disagreement, are REQUIRED*).

Student Signature

Date

Student's comments:

All supervisors/ faculty with responsibilities or actions described in the above competency remediation plan agree to participate in the plan as outlined above. Please sign and date below to indicate your agreement with the plan.

Director of Clinical Training

Date

Faculty/Supervisor Signature

Date

Faculty/Supervisor Signature

Date