DEPARTMENT OF PUBLIC SAFETY
NEW MEXICO STATE POLICE
SELECT ONE

Title/Name of Officer ______________________
Duration of CAP, if needed ______________________

Identified Deficiencies by the Supervisor:

Reasons Given by Employee for Deficiencies:

Requirement's and Suggestions for Remediation of Deficiencies:

Employee's Requirements/Suggestions

Supervisor's Requirements/Suggestions

Review Dates of CAP, if needed: (Minimum review is in 30 day increments)

Date				
________	Supervisor's Initials	________	Employee's Initials	________
________	Supervisor's Initials	________	Employee's Initials	________
________	Supervisor's Initials	________	Employee's Initials	________
________	Supervisor's Initials	________	Employee's Initials	________

Supervisor's Statement of Completion:

I have carefully reviewed the Corrective Action Plan/Counseling Form and will carry out the requirements outlined in it.

Employee Signature Date

First Level Supervisor Signature Date

Second Level Supervisor Signature Date

Third Level Supervisor Signature Date

Zone Major Signature Date