

**FCCP Individual Provider  
Plan of Work**

**Provider ID** \_\_\_\_\_

**Date Plan of Work Started** \_\_\_\_\_

**Follow-up Date** \_\_\_\_\_

*Complete this plan of work using the FCCERS and in consultation with your provider. Send the office the original in your 1<sup>st</sup> packet of the new quarter. At the end of the quarter, complete your follow-up (copy from office) and submit the 2<sup>nd</sup> copy in the last mailing of the quarter.*

Scale Item & Rating	Indicator(s) Not Met	Description of Concerns	Plans for Action (include materials and training needed, schedule, space, and supervision changes)	Expected Completion Date	Follow-up (e.g. changes made, date completed, time extended)

**Other specific Accreditation Plans:**