Institution submitting request: ____________________________________________

Program name and State Regents’ three-digit program code of Cooperative Agreement Program (CAP) to be suspended:

_______________________________________________________________________

Name of Technology Center(s) with which the CAP will be suspended:

_______________________________________________________________________
_______________________________________________________________________

**CAP SUSPENSION**

**NOTE:** Information not included on the requested action may cause a delay in processing.

Reason for requested action (attach no more than one page if space provided is inadequate):

Date CAP will be reinstated or deleted in:

☐ One year
☐ Two years
☐ Three years

Date CAP suspension effective:

☐ Immediate
☐ Beginning with academic year: ________________