CAL POLY
Counseling & Psychological Services
CAMPUS HEALTH & WELLBEING

# REQUEST TO CHANGE CAPS PROVIDER

FULL NAME (PRINTED) _____

DATE OF BIRTH ___/___/___

PHONE NUMBER _____

REASON

- ☐ I don't want to wait for my CAPS Provider's next available appointment
- ☐ I don't feel like my current CAPS Provider is a good fit
- ☐ My schedule conflicts with my current CAPS Provider's availability (please provide specifics)
- ☐ I am coming in for a different issue and I want to talk to a different CAPS Provider
- ☐ Other _____

_____

_____

_____

All requests will be responded to within 5 business days.

- ☐ I understand that this request will be reviewed by the Director/Clinical Director of Counseling & Psychological Services.
- ☐ I understand that the Director/Clinical Director may contact me by phone or secure message (Health and Counseling Portal) to discuss this request.

STUDENT SIGNATURE _____

DATE ___/___/___

**TO BE COMPLETED BY COUNSELING & PSYCHOLOGICAL SERVICES**

Date received: ___/___/___ Received by: _____

Reviewed by: _____ Approved: ☐ Yes ☐ No