Request for Refund or Test Date Transfer Form Page 2

Title: ________________________________

Given names: __________________________

Surname: ______________________________

Address: ______________________________________

________________________________________________________________________

Telephone: __________________________

Email: ______________________________________

Test date registered for: ______/____/____

Request is for (tick one box): □ Refund    □ Date transfer

Centre Name/Number: __________________________

Candidate statement (to be completed by the candidate)

________________________________________________________________________

Please detail your grounds for applying for a refund or a test date transfer (attach extra sheet if there is insufficient space).

Candidate signature: __________________________ Date: ________________

Received by: __________________________ Date: ________________

Test centre use only: Previous Request for Refunds/Transfer

<table>
<thead>
<tr>
<th>Registered test date</th>
<th>Date of prior application</th>
<th>Grounds for application</th>
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</thead>
<tbody>
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<td>Medical</td>
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Request (please selected)  □ APPROVED    □ NOT APPROVED

Authorised by: __________________________ Date: ________________

(IELTS Administrator)
Request for Refund or Test Date Transfer Form Page 3

Supporting documentation / evidence: Medical (This form must be accompanied by an original medical certificate.)

Professional Practitioner Certificate (to be completed by medical practitioner)

Date/s of consultation: ____________________

Candidate affected on the test day (please circle appropriate letter):
A totally unable to sit exam specify period
B very severely affected but able to sit exam specify period
C severely affected but able to sit exam specify period
D moderately affected but able to sit exam specify period
E slightly affected but able to sit exam specify period
F unable to assess ability to sit exam specify period

Candidate affected at some time prior to the test day (please circle appropriate letter):
A totally unable to sit exam specify period
B very severely affected but able to sit exam specify period
C severely affected but able to sit exam specify period
D moderately affected but able to sit exam specify period
E slightly affected but able to sit exam specify period
F unable to assess ability to sit exam specify period

Remarks: nature of illness and other relevant information (with reference to the candidate’s capacity to sit an exam) which will assist in any assessment of this application for special consideration.

Practitioner’s Name: ____________________

Address: ____________________

Phone number: ____________________

Signature: ____________________ Date: ____________________

Supporting documentation / evidence: Other (police report, military service notice, death notice).
Please specify and attach relevant documentation/evidence

Refund/test date transfer. If you choose not to complete all the questions on this form, it may not be possible for the test centre to process your request.