IELTS™
English for International Opportunity

The test that sets the standard

Request for Refund or Test Date Transfer Form

Personal Details

Title:

Given Names:

Surname:

Address:

Telephone:

Email:

Test Date Registered for (dd/mm/yyyy):

Request is for (tick one box): ☐ Refund ☐ Test Date Transfer

Centre name/number:

Preferred New Test Date (dd/mm/yyyy):

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 insuffcient space).

Candidate Signature: Date: (dd/mm/yyyy)

Received by: Date: (dd/mm/yyyy)

Test Centre Use Only: Previous Request for Refunds/Transfer

Registered Test Date (dd/mm/yyyy)	Date of prior application (dd/mm/yyyy)	Grounds for Application		
		Medical	Personal	Other
		☐	☐	☐
		☐	☐	☐

☐ Request approved ☐ Request NOT approved Date: (dd/mm/yyyy)

(IELTS Administrator)

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Supporting Documentation/Evidence: Medical

(This form must be accompanied by an original medical certifcate.)

Professional Practitioner Certifcate (to be completed by medical practitioner)

Date/s of consultation:

Candidate affected on the test day (please tick appropriate choice)

- ☐ Totally unable to sit exam — specify period
- ☐ Very severely affected but able to sit exam — specify period
- ☐ Severely affected but able to sit exam — specify period
- ☐ Moderately affected but able to sit exam — specify period
- ☐ Slightly affected but able to sit exam — specify period
- ☐ Unable to assess ability to sit exam — specify period

Candidate affected at some time prior to the test day (please tick appropriate choice)

- ☐ Totally unable to sit exam — specify period
- ☐ Very severely affected but able to sit exam — specify period
- ☐ Severely affected but able to sit exam — specify period
- ☐ Moderately affected but able to sit exam — specify period
- ☐ Slightly affected but able to sit exam — specify period
- ☐ 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:

Provider Number: (if applicable):

Stamp:

Signature: Date: (dd/mm/yyyy)

Supporting Documentation/Evidence: Other (police report, military service notice, death notice).

Please specify and attach relevant documentation/evidence

The information on this form is collected for the primary purpose of assessing your request for a 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.