



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 insufficient 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
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 certificate.)

Professional Practitioner Certificate (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.

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Practitioner's Name:

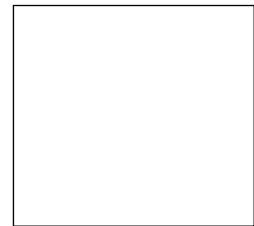
Address:

Phone Number:

Provider Number: (if applicable):

Signature:

Date: (dd/mm/yyyy)



Stamp:

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

Please specify and attach relevant documentation/evidence

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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.