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

<table>
<thead>
<tr>
<th>Registered test date (dd/mm/yyyy)</th>
<th>Date of prior application (dd/mm/yyyy)</th>
<th>Grounds for application</th>
<th>Other</th>
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<td>Medical</td>
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<td>Other</td>
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☐ Request approved ☐ Request NOT approved Date: (dd/mm/yyyy)

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

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
- [ ] Very severely affected but able to sit exam
- [ ] Severely affected but able to sit exam
- [ ] Moderately affected but able to sit exam
- [ ] Slightly affected but able to sit exam
- [ ] Unable to assess ability to sit exam

specify period

specify period

specify period

specify period

specify period

specify period

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

- [ ] Totally unable to sit exam
- [ ] Very severely affected but able to sit exam
- [ ] Severely affected but able to sit exam
- [ ] Moderately affected but able to sit exam
- [ ] Slightly affected but able to sit exam
- [ ] Unable to assess ability to sit exam

specify period

specify period

specify period

specify period

specify period

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): ____________________________

Signature: ____________________________

Date: (dd/mm/yyyy)

Stamp:

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.