IELTS™

Request for Refund or Test Date Transfer Form

Personal details

Title

Given names

Surname

Address/City

Telephone

Email

Test date registered for

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

Centre name/number BRITISH COUNCIL COLOMBIA / CO001

Preferred new test date

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

Registered test date	Date of prior application	Grounds for application		
		Medical	Personal	Other

Request (please select): **APPROVED** **NOT APPROVED**

Authorised by:
(IELTS Administrator) Date:

June 2017

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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 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:

Provider number: (if applicable):

Stamp:

Signature:

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.