



Request for Refund or Test Date Transfer Form

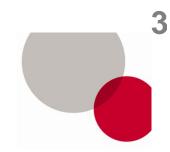
Personal details Title Given names Surname Address/City Telephone Email Test date registered for Request is for (tick one box) Refund Test Date Transfer Centre name/number Preferred new test date Candidate statement (to be completed by the candidate) Please detail your grounds for applying for a refund 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 Grounds for application Date of prior application Medical Personal Other **NOT APPROVED** Request (please select): **APPROVED** Authorised by:

Date:

June 2017

(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)

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Date/s	Ot (consi	iltati∩n:

Candidate	affected	on the	test day	(please	circle	appropriate	letter):

Α	totally unable to sit exam	specify period
В	very severely affected but able to sit exam	specify period
С	severely affected but able to sit exam	specify period
D	moderately affected but able to sit exam	specify period
Ε	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):

Α	totally unable to sit exam	specify period
В	very severely affected but able to sit exam	specify period
С	severely affected but able to sit exam	specify period
D	moderately affected but able to sit exam	specify period
Ε	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):	
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.