

Request for Refund or Test Date Transfer Form

Personal details

Title: _____

Given names: _____

Surname: _____

Address: _____

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: / /

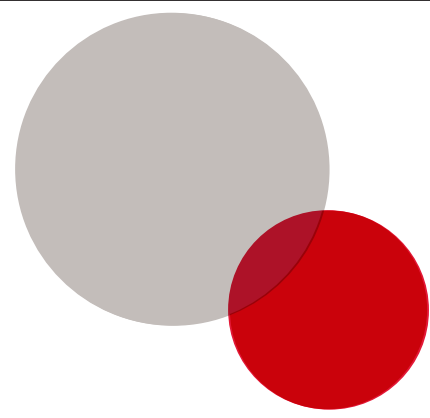
Test centre use only: Previous request for refunds/transfer

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

Request (please circle) APPROVED NOT APPROVED

Authorised by: _____ Date: / /

(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 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

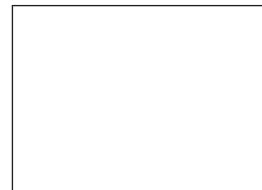
Practitioner's name: _____

Address: _____

Phone Number: _____

Provider number: (if applicable): _____ Stamp: _____

Signature: _____ Date: / /



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.