

# 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)

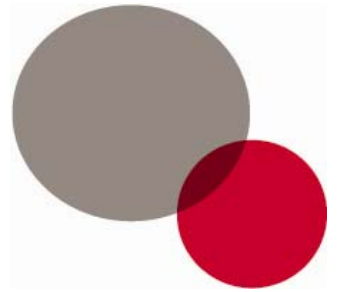
-----

### 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)



# 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                      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.

\_\_\_\_\_  
\_\_\_\_\_

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.