IELTS™
English for International Opportunity

The test that sets the standard

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
		☐	☐	☐
		☐	☐	☐

Request approved ☐ Request NOT approved ☐ Date: (dd/mm/yyyy)

(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 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): _____ Stamp:

Signature: Date: (dd/mm/yyyy)

_____

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.