

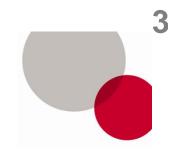


Request for Refund or Test Date Transfer Form

Personal de	tails			
Title:				
Given names:				
Surname:				
Address:				
Telephone:				
Email:				
Test date registered for:	[/] /			
Request is for (tick one b	pox): Refund	Test Date Transfer		
Centre name/number:	Universidad del Pa	cifico, Centro de	Idiomas - PE031	
Preferred new test date:	[/ [/			
Candidate statem	ent (to be completed by	the candidate)		
Please detail your groun (attach extra sheet if the	ds for applying for a refund or re is insufficient space).	or a test date transfer		
Candidate signature:			Date:	
Received by:			Date:	
Test centre use only: F	Previous Request for Refund	s/Transfer		
Registered test date	Date of prior Grounds for application application			
		Medical	Personal	Other
			Ī	
Request (please select):	APPROVED	NOT AF	PPROVED	
Authorised by: (IELTS Administrator)			Da	ate:

May 2014





Request for Refund or Test Date Transfer Form

Supporting documentation / evidence: Medical (This form must be accompanied by an original medical certificate.)

•		ner Certificate (to be completed	by medical practitioner)					
Date/s of consultation:								
Ca	Candidate affected on the test day (please circle appropriate letter):							
Α	totally unable to sit	exam	specify period					
В	very severely affect	ed but able to sit exam	specify period					
С	severely affected bu	ut 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	specify period				
F	unable to assess ability to sit exam		specify period					
Ca	andidate affected at	some time prior to the test day	(please circle appropriate letter):					
Α	A totally unable to sit exam		specify period					
В	B very severely affected but able to sit exam		specify period					
С	C severely affected but able to sit exam		specify period					
D	D moderately affected but able to sit exam		specify period					
Ε	E slightly affected but able to sit exam		specify period					
F	F unable to assess ability to sit exam		specify period					
		assessment of this application fo	i special consideration.					
Practitioner's name:		Ī						
Ad	ldress:							
Ph	one number:	Ī						
Pr	ovider number: (if ap	plicable):	Stamp:					
Się	gnature:							
		mentation / evidence: O ch relevant documentation/evide	Other (police report, military service notice, death notice).					

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