



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 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): _____

Signature: _____

Stamp: _____

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.