



Request for Refund or Test Date Transfer Form

Personal details

Form must be submitted within 5 working days of test date

Title: _____ Surname: _____

Given names: _____

Address: _____

Telephone: _____ Email: _____

Test date registered for: / / Centre Name/Number: **CELUSA AU100**

Request is for (Tick one box): Test Date Transfer Refund (75% of test fee refunded)

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).

Account details for refund:

BSB Number: _____ Account Number: _____

Name in which account is held: _____

Candidate Signature: _____ Date: / /



Admin Use Only:

Received By: _____ Receipt Number: _____ Date: _____

Test Centre Use Only:

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

Request : **APPROVED** **NOT APPROVED** Refund Amount: \$ **Invoice Number:** _____

Authorised by: _____ Date: / /

Accounts

Date received: / / Processed: / / Paid: / /

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