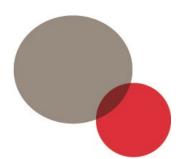
CONFIDENTIAL





Request for Refund or Test Date Transfer Form

Personal details	<u>Forr</u>	<u>n must be submitted w</u>	ithin 5 working da	ys of test date	
Title:	Surname:				
Given names:					
Address:					
Telephone:		Email:	Email:		
Test date registered for: / /		Centre Name/Nu	Centre Name/Number: CELUSA AU100		
equest is for (Tick one box): Test Date Transfer		nsfer Refund (7	Refund (75% of test fee refunded)		
Preferred New Test Dat	te: / /				
	ent (to be completed b nds for applying for a refun	d or a test date transfer (att	ach extra sheet if there	is insufficient space).	
Account details for BSB Number:	refund: 	Account Numbe	r:		
Name in which accoun	t is held:				
Candidate Signature:			Date: /	/	
Admin Use Only:			saibt	University of South Australia English Langu	
Received By:		Receipt Number	:	Date:	
Test Centre Use Only:	T	T	7		
Registered test date	Date of prior application	Grounds for application			
		Medical	Personal	Other	
Request : APPRO	VED NOT APPROVE	D Refund Amount: S	. Invoice	Number:	
•	VED NOTATIONE			Trumber.	
Authorised by:		Date: / /	, 		
Accounts					
Date received: /	/ Proce	essed: / /	Paid: /	/	
Oracla Cada: 100 22 04	14 111 14 1271 0 0 0				