

REQUEST FOR REFUND - DECISION FORM

Participant Name:		Participant ID Number:	
Address:			
Telephone/ mobile:		Email:	
Course:			
Reason for Refund request :			
Evidence assessed to support decision: Medical <input type="checkbox"/> Letters <input type="checkbox"/> Other <input type="checkbox"/> Please attach evidence:			

Participant Signature		Date	
-----------------------	--	------	--