Australian Medical Council Limited

CLINICAL EXAMINATION WITHDRAWAL NOTIFICATION

This form must be completed if you wish to withdraw from a clinical examination placement that you have accepted

AMC CANDIDATE NUMBER		DATE OF BIRTH	
FAMILY NAME		GIVEN NAME	
ADDRESS		EXAMINATION DATE WITHDRAWING FROM	
REASON OF WITHDRAWAL (Attach Medical Certificate or Statutory Declaration)			
Date Invoice /receipt issued			

CLINICAL EXAMINATION WITHDRAWAL

Once a candidate is scheduled in a Clinical examination and then subsequently withdraws, the following will apply –

1. *Withdrawal after examination fee payment has been made* ***– No refund***

2. *Non-attendance on examination day –* ***No refund***

A partial refund may be considered in an exceptional circumstance as determined by the AMC Chief Executive Officer or nominee.

- *Request must be made in writing, accompanied by a doctor's certificate or Statutory Declaration and any relevant supporting documentation.*
- *Withdrawals due to personal circumstances such as minor illness, visa application issues or travel arrangements are the responsibility of the candidate and will not be accepted as an exceptional circumstance.*
- *Should a refund be granted following review of circumstances, 50% of the examination fee will be refunded.*
- *The AMC is not able to reschedule an examination placement.*

(If a refund is applicable, please complete your Credit Card details below, noting reimbursement must be processed onto the original card used for payment)

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Expiry Date: __ __/__ __

Cardholder's Name: _____ Signature: _____

Your privacy is respected by the AMC. Information collected by the AMC may be used for administering the AMC examination and provided to AMC Examiners and State and Territory Medical Boards. The AMC privacy procedures are set out in a Policy Statement which can be obtained from the AMC. If you have any privacy concerns or would like to verify information held about you please contact the Privacy Officer, Australian Medical Council Limited, PO Box 4810, KINGSTON, ACT, 2604.

Confirmation of withdrawal and **Consent to collect information**:

Signature: _____ Date: _____

PLEASE RETURN THIS FORM VIA EMAIL: clinical@amc.org.au