

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

AMCCANDIDATE NUMBER

DATE OF BIRTH

FAMILY NAME

GIVEN NAME

ADDRESS

EXAMINATION 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