**CANCELLATION REQUEST FORM**

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| --- | --- |
| Applicant Name: | [Your Full Name] |
| Test Date: | [Scheduled Test Date] |
| I, the undersigned, hereby request the cancellation of my scheduled test on the above-mentioned date. I understand that failure to provide timely notice may result in the forfeiture of payment without a refund. | |
| Reason for Cancellation (optional): | [Please provide a brief explanation] |
| Signature |  |
| Date |  |

Please submit this form to the Examination Office at least 10 days before the scheduled test date.

**Form: SS-LPAB 2-11**