



Canadian Association of Registered Diagnostic Ultrasound Professionals
Association Canadienne des Professionnels Autorisés en Échographie Diagnostique

CARDUP ACPAED

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Exam Withdrawal and Refund Request must be received by CARDUP within 5 business days of your scheduled exam.

CARDUP Examination Withdrawal and Refund Request

1. IDENTIFICATION (PLEASE PRINT OR TYPE LEGIBLY.)

_____ Date: _____
 First Name Middle Initial Last Name (date / month / year)

_____ Street Address

_____ P.O. Box or Rural Route (if applicable) _____ City

_____ Province _____ Postal Code _____ Country

_____ CSDMS / CARDUP No. (if applicable) _____ Date of Birth (date / month / year)

(____) _____ (____) _____
 Home Telephone Number Work Telephone Number

2. FROM WHICH SPECIFIC EXAMINATION(S) ARE YOU REQUESTING WITHDRAWAL AND A REFUND:

<input type="checkbox"/> Core	<input type="checkbox"/> May	<input type="checkbox"/> BCIT	<input type="checkbox"/> Michener
<input type="checkbox"/> Generalist	<input type="checkbox"/> September	<input type="checkbox"/> NAIT	<input type="checkbox"/> Collège Boréal
<input type="checkbox"/> Cardiac	<input type="checkbox"/> January	<input type="checkbox"/> SAIT	<input type="checkbox"/> QEII / Dalhousie School of Health Sciences
<input type="checkbox"/> Vascular	Indicate Year _____	<input type="checkbox"/> Winnipeg Health Sciences	<input type="checkbox"/> College of the North Atlantic
		<input type="checkbox"/> Mohawk	

3. PLEASE INDICATE THE REASON FOR WITHDRAWAL FROM THE EXAM (OPTIONAL).

4. METHOD OF REFUND OF EXAMINATION FEES (LESS THE \$100.00 MANDATORY NONREFUNDABLE EXAM APPLICATION PROCESSING FEE)

Cheque Money Order

MasterCard VISA

Signature of Cardholder: _____ Account Number: _____

Expiry Date: _____

FOR CARDUP OFFICE USE ONLY

Date received: _____ Date of Processing & Refund: _____

Special Notes: _____