Sonography Canada / Échographie® Canada

Request must be received by Sonography Canada no later than The dates noted on our website.

Examination Withdrawal and Refund Request

1. IDENTIFICATION (PLEASE PRINT OR TYPE CLEARLY)

First Name _____ Middle Name/Initial _____ Last Name _____ Date: _____ (D / M / Y)

Address _____

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

Province _____ Postal Code _____ Country _____

Sonography Canada No. (if applicable) _____

Telephone Number _____

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

- ☐ Core
- ☐ Cardiac
- ☐ Vascular
- ☐ Generalist

- ☐ January sitting
- ☐ May sitting
- ☐ September sitting

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

_____

FORWARD WITHDRAWAL BY EMAIL TO:

EXAMINFO@SONOGRAPHYCANADA.CA

FOR OFFICE USE ONLY

Date received: _____ Date of Processing & Refund: _____

Special Notes: _____