Complementary Healthcare Council of Australia

Application for Refund

Payee Details:

Customer Name:____

Address:____

ABN: _ _ _ _ _ _ _ _ _ _ _

Transaction Details:

Invoice Number:____________________ **Invoice Date:**_____________________

Invoice Amount:$___________________

Payment Method: Cheque Visa MasterCard Diners Amex EFT

Reason for Refund:

____

____

____

____

Name of person requesting refund:____________________________________

Position Held:____

Signature: ___________________________________ Date: / /

Send completed form to: Finance Section CHC PO Box 104 Deakin West ACT 2600
or Fax: 02 6260 4122
or Email: finance@chc.org.au

Office Use Only:			
Task	**Name**	**Signature**	**Date**
Original Payment amount and method verified			
Reason for refund accepted			
Refund approved			
Refund processed			