Request Form

Requests for Official CanTEST results to be mailed to another Institution.

Test Date: ______________________ U of R ID: __________________________
Family Name: _______________________________________________________
First Name: __________________________________________________________
Phone: __________________________________________________________________
Birthdate: ______________________ □ Male □ Female
(day/month/year)

Institution Address – where results are to be sent. **$10.00 fee applies**

Institution Name: ______________________________________________________
Institution Contact: _____________________________________________________
Address: __________________________________________________________________
City: ______________________ Province: ______________________
Postal Code: ______________________ Telephone: ______________________

Payment Information

Method of Payment: □ Visa □ Mastercard □ Amex □ Debit (In office only)

Credit Card Number:_____________________________ Expiry Date: Month______ Year ________
_________________________________________ Signature __________________________________________
_________________________________________ Date __________________________________________