American Board of Advanced General Dentistry

Exam Cancellation Request Form

Please complete this form to request cancellation of your scheduled ABAGD examination (Part One – Written or Part Two – Oral). Refunds are issued only in accordance with ABAGD policy.

Candidate Information

Full Name: _____
Candidate ID Number: _____
Address: _____
City / State / Country: _____
Email: _____
Phone Number: _____

Exam Details

Exam Type (Written / Oral): _____
Scheduled Exam Date: _____
Exam Location: _____

Reason for Cancellation

_____
_____
_____

Refund Policy

- Cancellations received ≥30 days before exam date: 50% refund.
- Cancellations received <30 days before exam date: Non-refundable.
- Refunds processed within 6–8 weeks.

Declaration

I declare that the above information is correct. I understand that my request will be processed according to ABAGD policies and that fees may be forfeited in accordance with the refund policy.

Candidate Signature: _____ Date: _____