REQUEST FOR REFUND

PLEASE PRINT LEGIBLY

CUSTOMER INFORMATION

CUSTOMER'S FULL NAME	GEORGIA DRIVER'S LICENSE / ID #

PAYER'S FULL NAME, IF DIFFERENT	CONFIRMATION / BATCH / RECEIPT #

MAILING ADDRESS OF PAYER (CHECK MAY BE MAILED TO THIS ADDRESS)	CITY	STATE	ZIP CODE

DATE OF PAYMENT

AMOUNT OF PAYMENT $

METHOD OF PAYMENT ☐ CASH ☐ CREDIT CARD (LAST 4 DIGITS) _____ ☐ CHECK ☐ MONEY ORDER

LOCATION OF PAYMENT ☐ CSC#: ☐ ONLINE ☐ MAIL ☐ DDS 2 GO

PHONE NUMBER OF PAYEE

PAYER EMAIL ADDRESS

REASON FOR REFUND (CHECK ONE):

☐ Overpayment
☐ ALS Hearing
☐ CSC Team Member Error
☐ Duplicate Payment
☐ Other (please explain):

☐ Reinstatement Paid Prior to Effective Date
☐ Incorrect Purchase (Not Processed) *
☐ Need Interim Immediately (Not Processed) *
☐ Court Correction
☐ CDL Skills Test Reservation #_____

* **Pursuant to DDS rule, payments remitted online or via DDS 2 GO are eligible for refunds until midnight of the day of purchase.**

AUTHORIZATION - FOR DDS USE ONLY

DDS TEAM MEMBER NAME (CSC ONLY)	DDS TEAM MEMBER SIGNATURE (CSC ONLY) X	DATE	RECEIVED AT ☐ CSC#: _____
MANAGER NAME	MANAGER SIGNATURE X	DATE	☐ HQ

FOR ACCOUNTING USE ONLY

DECISION ☐ APPROVED ☐ NOT APPROVED	REASON

REASON (CONTINUED)

REFUND AMOUNT $	REASON, IF REFUND AMOUNT DIFFERENT THAN AMOUNT OF PAYMENT

FINANCE MANAGER NAME	FINANCE MANAGER SIGNATURE X	DATE

REVENUE DEPARTMENT		ACCOUNTS PAYABLE DEPARTMENT	
REVENUE ACCOUNT	FUND	VOUCHER #	CHECK #
ORGANIZATION CODE	FUNDING SOURCE	VENDOR #	INVOICE #
OPB PROGRAM	PROJECT	ENTERED BY	DATE